VILLAGE DENTAL CLINIC
General & Cosmetic Dentistry

NEW PATIENT MEDICAL & DENTAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. Please note that all information on this medical & dental history form will remain strictly confidential. Please complete in **CAPITAL LETTERS**.

PATIENT DETAILS:

Title	Mr./Mrs./Miss./Ms./Master/(Other) _____		
Given Names			
Surname			
Occupation		Date of Birth	
Phone (H) Phone (W) Phone (M)	☐ ☐ ☐ (Please tick a box above that you prefer we contact you on)	Home Address	
Email Address			
Health Fund (If applicable)		Member Number	
Emergency Contact	Name: Phone Number: Relationship:		

MEDICAL HISTORY:

Name of your Family Doctor:		Your Doctor's Phone Number:	

Have you ever had or are you suffering from any of the following? Please tick that apply:

☐ Diabetes	☐ Kidney Disease	☐ Prosthetic Implant
☐ Heart Disorder/Complaint	☐ Excessive Bleeding	☐ Cardiac Pacemaker
☐ Asthma	☐ Stroke	☐ Stomach or Digestive Condition
☐ Steroid Therapy	☐ Cancer	☐ Hepatitis or Other Liver Diseases
☐ Radiation Therapy	☐ Tuberculosis	☐ Lung Disease (eg. Bronchitis)
☐ Rheumatic Fever	☐ Thyroid Disease	☐ Blood Disease (eg. Anaemia)
☐ Bone Disease - Osteoporosis	☐ Nervous or Psychiatric Condition	☐ Allergy to Penicillin
☐ Epilepsy	☐ High or Low Blood Pressure	☐ Allergy to Medications
☐ Fainting Disorder	☐ Sleep Apnoea	☐ Allergy to Latex

Any other Condition(s) not mentioned (Please list):

For Women: Are you pregnant? If yes, how many months?

Have you been a patient in hospital during the past 2 years? If yes, please provide more information.	
Are you taking any medication? If yes, please provide more information.	
Do you smoke? If so how many per day?	

DENTAL HISTORY:

Are you concerned about or experiencing any of the following dental problems? (Please tick as many as it applies)

☐ Sensitivity to hot or cold	☐ Food trapping between teeth	☐ Clicking/pain in the jaw joints
☐ Staining of your teeth	☐ Discoloured fillings / teeth	☐ Roughness of existing fillings
☐ Bleeding gums	☐ Bad breath	☐ Sensitivity when eating
☐ Head/Neck Ache	☐ Grinding/clenching of your teeth	☐ Existing crowns/bridges/dentures

What is the main purpose of your visit today?	
How long since your last dental visit?	

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had or require the following for dental treatment?

☐ Gas (Nitrous oxide-laughing gas) ☐ Intravenous sedation ☐ General Anaesthesia

REFERRAL INFORMATION:

☐ Internet/Website ☐ Walk-By ☐ Brochure in Letter Box ☐ Other _____

☐ Friend/Family (Please provide name so that we can thank them): _____

MODE OF PAYMENT: ☐ Cash ☐ Credit Card ☐ EFT ☐ Direct Deposit ☐ Cheque ☐ Other _____

CONSENT FOR SERVICES:

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee may be incurred if I fail to do so.
- I hereby authorize the dentist or the designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
- I am aware that payment is required on the day of treatment.
- We provide a courtesy to our patients a preventative recall program that offers a call service if you have not been to the practice in 6 months.

Patient/Parent/Responsible Person Signature _____ Date: _____