Medland DENTAL CENTRE
Technical excellence. Exceptional care.

NEW PATIENT MEDICAL HISTORY

These details provide us with information required for your optimal dental treatment and oral health care.
Your Privacy & Confidentiality will be respected at all times. To view our policy please ask for a printout.
Please feel free to discuss any health questions in confidence with your Dentist.

First Name:	Surname:
Title: Miss / Mrs / Ms / Master / Mr / Dr / Prof / Rev / Sister	Occupation:
Date of birth:	Address:
Home Phone:	Postcode:
Mobile Phone:	Work Phone:
Email:	Preferred Contact: Mobile / Email / Home / Work / SMS
Private Health Insurance:	

Have you had any of the following? (tick)

Heart problems	☐	Diabetes	☐
Blood pressure	☐	Asthma	☐
Artifical joints	☐	Epilepsy	☐
Rheumatic fever	☐	Hepatitis ABCDE	☐
Circulatory problems	☐	Liver or Kidney problems	☐
Radiation treatment	☐	Osteoporosis	☐
Excessive bleeding/bruising	☐	Allergies to anaesthetics	☐
Mental illness	☐	Allergies to penicillin	☐
Sinus trouble	☐	Allergies to medications	☐
Cancer History	☐	Allergies to latex	☐
Anemia or other blood disorder	☐	Other _____	☐
Do you smoke?	☐ Yes ___per day		☐ No
Are you pregnant? (females)	☐ Yes		☐ No
Are you currently taking medications?	☐ Yes		☐ No

If yes, please list: _____

_____

_____

Name of your doctor: _____ Phone no: _____

Next of kin & relationship: _____ Phone no: _____

Your Privacy and Confidentiality

To achieve your optimal dental care it may be necessary to consult with other dental professionals. In some cases we are asked questions on the phone by parents, spouses or friends with regard to appointments or treatment; we need your consent to disclose any details. I give my permission to discuss my dental care when necessary with:

1. Other dental professionals: Yes / No 2. Family members: Yes / No 3. Non-family members: Yes / No

Continued overleaf →

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Does you jaw click or hurt?	☐	Yes	☐	No
Do you grind your teeth?	☐	Yes	☐	No
Have you had orthodontic treatment?	☐	Yes	☐	No
Do you wear a night guard/splint?	☐	Yes	☐	No
Do you experience sleep apnoea?	☐	Yes	☐	No
Have you ever had gum disease?	☐	Yes	☐	No
Do you think you have occasional bad breath?	☐	Yes	☐	No
Do your gums ever bleed when you brush?	☐	Yes	☐	No
Do you experience sensitivity to hot or cold?	☐	Yes	☐	No
Does floss ever tear between your teeth?	☐	Yes	☐	No
Do your teeth ever hurt when you bite hard?	☐	Yes	☐	No

How long since your last dental appointment?

How often do you have dental examinations? _____

Previous dental x-rays were taken how long ago? (approx) _____

As we like to thank current patients or other healthcare providers for their kind referrals, if you were referred please provide the name of the person who referred you _____

How did you hear about our practice?

Yes

☐ Yellow Pages ☐ Other Health Professional
☐ Signage ☐ Flyer ☐ Google ☐ Web (other)
☐ Event ☐ Advertisment
☐ Walked by

Other (Please specify) _____

From time to time Medland Dental Centre emails or posts educational material,newsletters and/or promotional material to our patients. Please indicate if you would like to be included when Medland Centre distributes this information ☐ Yes ☐ No

From time to time Medland Dental Centre conducts in-house surveys and/or third party managed surveys. Please indicate if you would like to be included when Medland Dental Centre conducts these surveys ☐ Yes ☐ No

Consent for treatment

I hereby authorise Medland Dental Centre to take x-rays, study models, photographs & other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me & to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives & other medication as necessary. I fully understand I can ask for a full recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf & on behalf of my dependents. I understand that payment is due at the time of service.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____

Relationship to patient: _____ Dentist Signature: _____