Rainbow Dental and Medical Practice

NEW PATIENT MEDICAL & DENTAL HISTORY FORM

Please note that all information on this medical/dental form will remain strictly confidential. Please complete in **CAPITAL LETTERS.**

Surname		Given Names	
Date of Birth		Occupation	
Phone (H) Phone (W) Phone (Mobile)	☐ ☐ ☐ (Please tick the box that you prefer we contact you on)	Home Address	
Email address			
Health Fund		Member Number:	
Emergency contact (please provide name and phone number):			

To complete only if the patient is under 18 years old

Guardian Name & Contact Address/Phone Details	

Referral Information

☐ Internet/Website ☐ Walked past ☐ Yellow Pages ☐ Village Voice

☐ Patient (please provide name so that we can thank them) _____

MEDICAL HISTORY

Name of your GP:		Your Doctor's Phone No.	
Your Doctor's address:			

Have you ever had any of the following? Please tick those that apply:

☐ Anaemia	☐ Fainting	☐ Pacemaker
☐ Artificial joints	☐ Glaucoma	☐ Radiation Therapy
☐ Asthma	☐ Heart Disease	☐ Respiratory problems
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatic fever
☐ Cancer	☐ Hepatitis A, B, C	☐ Sinus problems
☐ Dizziness	☐ Jaundice	☐ Stroke
☐ Epilepsy	☐ Kidney Disease	☐ Tuberculosis
☐ Excessive Bleeding	☐ Liver Disease	☐ Tumours
☐ Diabetes	☐ HIV/ AIDS	☐ Psychological Disorders
Are you pregnant? If yes, how many months?		

Have you had any serious illnesses in the last 2 years? If yes, please provide more information.	
Are you currently taking any medications or tablets regularly? If yes, please provide more information.	
Do you have any allergies to Penicillin or other drugs? If yes, please provide more information.	
Do you suffer from sleep apnoea?	
Is your blood pressure normal, high or low?	
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
- ☐ staining of your teeth
- ☐ bleeding gums
- ☐ head/neck ache
- ☐ food trapping between your teeth
- ☐ discoloured fillings
- ☐ bad breath
- ☐ grinding or clenching of your teeth
- ☐ clicking/pain in the jaw joints
- ☐ roughness of existing fillings
- ☐ sensitivity when eating

Are you concerned with: (please tick as many as it applies)

- ☐ Existing crowns, bridges or dentures
- ☐ Tooth clean techniques (e.g. Brushing / Flossing)
- ☐ Crooked teeth
- ☐ Missing teeth
- ☐ Ability to eat
- ☐ Your smile
- ☐ Silver fillings
- ☐ Gaps between your teeth
- ☐ Discolouration of your teeth
- ☐ Previous dental treatment

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

I understand that payment is required on the day of treatment.

Signature: ..... Date: ..... Failure to give 24 hours notice for appointment changes incur a cancellation fee of $50.00