KENMORE DENTAL CENTRE
MEDICAL/DENTAL HISTORY

The information you provide is confidential and will be handled in accordance with the privacy policy established by the Australian Dental Association (ADA).

Title *(eg Mr/Mrs/Ms):*	Last Name:	First name(s):
Date of birth:	Email address:	
Home address:		
Suburb:		Postcode:
Postal address:		
Suburb:		Postcode:
Ph (hm):	Ph (wk):	Mob:
Name of emergency contact person:		Phone No:
Name of your medical practitioner:		Phone No:
I like to be reminded about my appointment by (please circle):	PHONE EMAIL SMS	
Are you in a health fund? Yes / No If yes, which health fund?		
How did you hear about us? (please circle) **Friend/Family (Please list so that we can thank them):**_____ Internet sources: GOOGLE YELLOW PAGES ONLINE OUR WEBSITE TRUE LOCAL FACEBOOK Yellow pages Health Fund Other:_____		

	Yes	No
Do you normally require antibiotic cover before dental treatment?		
Have you had any abnormal reactions to local or general anaesthesia?		
Do you smoke, or have you ever smoked in the past?		
Females, are you pregnant? Due Date:		
Please list current medications/ vitamins/supplements:		
Please list any allergies that you may have:		

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please tick yes for each condition, and circle an option if necessary

	Yes	No		Yes	No
Heart condition			HIV or AIDS		
High or Low blood pressure (please circle)			Hepatitis or other liver diseases		
Excessive bleeding			Osteoporosis		
Cancer			Previous Rheumatic fever		
Prosthetic implant or pacemaker			Kidney disease/disorders		
Sleep Apnoea			Nervous or psychiatric disorders		
Epilepsy			Steroid Therapy		
Asthma			Thyroid disease		
Diabetes			Radiation therapy		
Bronchitis, emphysema or other respiratory disorders			Anaemia, leukaemia or other blood disorders		

Any other condition (s) not mentioned (please list):

DENTAL HISTORY QUESTIONNAIRE:

When was the last time you had a full dental examination?

Is there anything in particular that is concerning you about your teeth/gums?

How nervous are you about your appointment today (please circle)?

NOT VERY 2 3 4 5 6 7 8 9 VERY ANXIOUS

Please answer yes/no to the following questions

	Yes	**No**
Do you suffer from jaw pain, jaw clicking or popping, or frequent headaches?		
Do you snore?		
Do you suffer from sensitive teeth?		
Do your gums bleed when you brush or floss?		
Have you had your wisdom teeth removed?		
Have you had orthodontic treatment in the past?		

Would you be interested in:

	Yes	**No**
Improving the appearance of your smile?		
Whitening your teeth?		
Straightening your teeth with braces or Invisalign (invisible braces)?		

Have you had any dental treatment in the past that you would like us to know about?

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and 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 and to employ such assisted as required to provide proper care. I agree to the use of anaesthetics', sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be made responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the same time of treatment.

I understand that any appointment that I book is a specific time reserved just for me. I endeavour to provide at least 24 hours notice if I wish to change or cancel appointments to avoid being charged a cancellation fee.

Patient Signature: **Date:**

Parent/guardian signature: **Date:**

Relationship to patient: