THE BONDI DENTISTS

CONFIDENTIAL PATIENT DETAILS

Dr/Mr/Mrs/Ms/Miss (Please circle)

Surname _____ Given Names _____

Private Address _____ Postcode _____

Telephone _____ Mobile _____

Email _____ Date of Birth _____

Work Address _____ Postcode _____

Telephone _____ Preferred day time contact: H / W / Mb

Occupation _____

You were referred/recommended by _____

May we thank this person for recommending you? YES / NO

My medical practitioner is _____ Telephone _____

Any other infectious diseases? _____

CONFIDENTIAL MEDICAL HISTORY

SSOME MEDICAL CONDITIONS OR MEDICATIONS MAY BE ADVERSELY AFFECTED BY ROUTINE DENTAL TREATMENT

Are you allergic to: ☐ Latex ☐ Penicillin ☐ Local Anesthetic ☐ Iodine

Anything else? _____

Are you taking any drugs or medication? YES / NO

If so, please list: _____

Please tick the box if you have ever had any of the following medical treatments/conditions?

☐ Tuberculosis ☐ Hepatitis A B C D E ☐ HIV/AIDS

☐ Anticoagulants/Aspirin	☐ Antidepressants	☐ Arthritis
☐ Bleeding/Bruising	☐ Bisphosphate Therapy	☐ Blood Disorder
☐ Blood Pressure Low/High	☐ Cancer/CNS/Tumour	☐ Circulatory Condition
☐ Diabetes	☐ Epilepsy/Tremors	☐ Gastric Reflux
☐ Glaucoma	☐ Heart Condition	☐ Joint Surgery
☐ Liver/Kidney Disorder	☐ Migraines/Headaches	☐ Muscle Disorder/Dystrophy
☐ Neurologic Disorder	☐ Osteoporosis	☐ Psychiatric Treatment
☐ Radiation/Chemotherapy	☐ Respiratory Disorder/Asthma	☐ Rheumatic Fever
☐ Sinus Condition	☐ Sleep Apnoea/Snoring	☐ Stroke
☐ Stent	☐ Thyroid Condition	☐ TMJ (Jaw) / Facial Condition
☐ Transplants	Anything else? _____	

IS THERE ANYTHING ELSE THAT YOU SHOULD MENTION, BUT YOU DO NOT WISH TO WRITE DOWN, THAT YOU SHOULD DISCUSS WITH THE DENTIST? YES / NO

Do you smoke? YES / NO

Would you like to try 'HAPPY GAS' to relax you during your treatment? YES / NO

CONFIDENTIAL MEDICAL HISTORY

Please tick the appropriate box that applies to you:

	Previously	Currently	Never
Discomfort in the face, head, neck, jaw	☐	☐	☐
Food catching between teeth	☐	☐	☐
Floss catching/tearing between teeth	☐	☐	☐
Bleeding or sore gums	☐	☐	☐
Occasional bad breath	☐	☐	☐
Teeth tender to chew on	☐	☐	☐
Teeth sensitivity to cold	☐	☐	☐
Teeth sensitivity to heat	☐	☐	☐
Teeth sensitivity to sweets	☐	☐	☐
Jaw joint clicking	☐	☐	☐
Jaw joint locking or sticking	☐	☐	☐
Pain in jaw	☐	☐	☐
Pain in ear	☐	☐	☐
Grind or clench teeth	☐	☐	☐
Loose teeth	☐	☐	☐
Loose fillings	☐	☐	☐
Chipped or broken teeth or fillings	☐	☐	☐

Any other dental problems? _____

_____

What is the reason for making this appointment? _____

_____

How long since your last dental appointment? _____

_____

How often do you have dental examinations? _____

_____

Previous dental radiographs (xrays)? ☐ Less than a year ago ☐ More than a year ago

Have you ever had orthodontic treatment? _____

Do you wear a dental nightguard? _____

_____

Have you ever had periodontal gum treatment? _____

_____

Have you ever had your bite adjusted? _____

_____

What, in relation to your teeth, would you like to improve or change? _____

_____