MY HillsDentist.com

38 Merindah Road
Baulkham Hills NSW 2153
Tel (02) 9686 7375
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Health History Form

So that we can ensure we are looking after your needs, please review and complete the following questionnaire:

Surname: (Mr/Mrs/Miss/Ms/Dr):	First Name:
DOB:	Address (House Number and Street Name):
Suburb/postcode:	Home Phone:
Work Phone:	Mobile:
Email:	Occupation:
Name of person responsible for fees, if not self: Their address:	

Recommended by: ____

Purpose of visit: ____

Health Fund for Dental: ____________________________________

Is another member of your family a patient at our office? Yes/no

Have you had any of the following? (If yes, please mark)

Heart Problems [ ]
Blood pressure [ ]
Artificial joints [ ]
Rheumatic fever [ ]
Circulatory problems [ ]
Radiation treatment [ ]
Excessive bleeding [ ]
Excessive brushing [ ]

Ulcers (stomach) [ ]
Sinus trouble [ ]
Tumour history [ ]
Anaemia [ ]
Blood disorders [ ]
Diabetes [ ]
Asthma [ ]
Hepatitis A B C D E [ ]

Epilepsy [ ]
Liver or kidney problems [ ]
Other [ ] ____________
____
____

Allergies: ____

____

Current Medications: ____

____

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Have you had any of the following?

Does your jaw ever click?..Yes/No
Do you feel you grind your teeth?...................................Yes/No
Have you ever had Orthodontic treatment?.........................Yes/No
Do you wear a night guard?...Yes/No
Have you ever had gum disease?.....................................Yes/No
Do you bite your lips or cheeks often?..............................Yes/No
Do you smoke?..Yes/No
Do you think you have occasional bad breath?.....................Yes/No
Do you gums ever bleed when you brush you teeth?...........Yes/No
Do you experience sensitivity with hot or cold?...................Yes/No
Does floss ever tear between your teeth?............................Yes/No
Does food get jammed between your teeth?........................Yes/No
Do your teeth ever hurt when you bite hard?.......................Yes/No

Do you see a regular Medical General Practitioner? Yes/No
Name of physician: ______________________________________
Address: ____
Phone: ____

Are you Pregnant? Yes/No   If yes, what is the due date? ____________
How long since your last dental appointment? ____________________
How often do you have dental examinations? _____________________
Previous dental x-rays were taken: Less than a year ago or longer than a year?
____

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and the use of my photographic likeness in all forms for advertising and any other lawful purposes, and to take 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 assistance 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 responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at this time of service unless other arrangements have been made. I understand that I will be required to pay the account as well as administration/ legal fees for recovery of accounts not paid.

I authorise this data may be reviewed by team members of the dental practice.

Patient signature:_________________________________

Date:____________________

Parent/responsible party's signature: _____________________

Relationship to patient: ____________________________