Encounter Bay Dental
5/66 Victoria Street, Victor Harbor, SA, 5211
Ph: 8552 9299 email: encounterbaydental@outlook.com

Medical History Questionnaire

It is important for your dentist to have your medical history and understand your health needs before any examination or treatment is carried out. Medical information will be kept strictly confidential, in accordance with the Privacy Act 1988.

Your Personal Details

Title Dr/Mr/ Mrs/ Miss/ Ms/ Other Date of Birth (DD/MM/YYYY)_____/_____/_____

First name(s)_____Surname_____

HomeAddress_____

_____Postcode_____

PostalAddress_____Postcode_____

Phone(Hm)_____(Mob)_____(Wk)_____

Email address_____

Health Fund_____Membership No_____Patient ID_____

Medicare No_____Patient ID_____

Veterans' Affair Card No_____

Details of contact in case of emergency

Emergency Contact_____Relationship to Patient_____

Telephone_____

Medical Questionnaire - Private and Confidential

Please answer these questions fully or discuss them with your dentist, information about your medical history is for your dentists use only.

Are you receiving any medical treatment at present? Y ☐ N ☐

Have you had any serious or long standing illness? Y ☐ N ☐

Have you ever been hospitalised? Y ☐ N ☐

If Yes, Details_____

Please indicate if your have EVER has any of the following:

Any heart complaint/treatment	Y ☐ N ☐	Tuberculosis	Y ☐ N ☐
Rheumatic Fever	Y ☐ N ☐	Any nervous system disorder	Y ☐ N ☐
High Blood Pressure	Y ☐ N ☐	Gastric Ulcer	Y ☐ N ☐
Low Blood Pressure	Y ☐ N ☐	Asthma/Bronchitis/Lung Condition	Y ☐ N ☐
Blood Disorders	Y ☐ N ☐	Radiation Therapy/Chemotherapy	Y ☐ N ☐
Anti-Coagulant Therapy	Y ☐ N ☐	Thyroid Disease	Y ☐ N ☐
Joint Replacement Surgery	Y ☐ N ☐	Hepatitis/Jaundice/Liver Disease	Y ☐ N ☐
Osteoporosis/Low Bone Density	Y ☐ N ☐	Treatment for any form of Cancer	Y ☐ N ☐
Epilepsy	Y ☐ N ☐	Transplanted Organ or Bone Marrow	Y ☐ N ☐
Diabetes (Is it controlled)	Y ☐ N ☐ Y ☐ N ☐	Pregnant (when due)_____	Y ☐ N ☐
HIV/AIDS	Y ☐ N ☐	Cognitive Impairment	Y ☐ N ☐

Do you smoke Y ☐ N ☐ Social ☐ Have you previously smoked? Y ☐ N ☐

Current Medications (prescription, over the counter, herbal)

_____

_____

Allergies (medicines i.e. penicillin, substances or materials (latex/rubber))?

Nil Known ☐ Yes ☐ - Please Detail_____

Have you ever had any ill effects following dental treatment? Y ☐ N ☐

Have you ever had any ill effects from local anaesthetic? Y ☐ N ☐

General Practitioner_____Phone Number_____

Have you seen your GP during the past year? Y ☐ N ☐

Dental History

Have you experienced any discomfort in your teeth recently? Y ☐ N ☐

Are you aware of any grinding or clenching of your teeth? Y ☐ N ☐

Do your jaw joints ever hurt or click? Y ☐ N ☐

Do you suffer from headaches or migraine pains in your face or ear? Y ☐ N ☐

Do your gums bleed easily, feel tender or irritated? Y ☐ N ☐

Are you troubled with bad breath or bad taste? Y ☐ N ☐

Would you like to know more about?

Teeth whitening Y ☐ N ☐ Straightening Y ☐ N ☐ Replacing missing teeth Y ☐ N ☐

I agree that the above is a true and accurate record. Payment on the day is required. Any expenses, costs or disbursements incurred by Encounter Bay Dental in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may result in a failure to attend fee.

PLEASE NOTE: The medical history questionnaire will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. this form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatment.

Patient Signature Date:

Dentist Signature Date:

OFFICE USE ONLY

Form checked by _____ Date Keyed by _____ Keying Checked by _____ Form Scanned By_____