New patient
Medical and dental history

smileline
DENTAL CARE

Dr Nasser Elhage | Dr Sarah Kara-Ali
Dr Eliedia Boustani | Miss Salli Adil Ali

Date:

Patient details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other

Surname: Given name: D.O.B:

Residential address:

Suburb: State: Postcode:

Postal address (if different):

Home phone: Work phone: Mobile:

Email:

☐ We will send you email communications from time to time, including appointment reminders and our regular newsletter. Please tick this box if you don't wish to receive communication from us.

Occupation: Company:

Emergency contact: Phone: Relation:

Private health insurer: Member #: Patient #:

Medicare #: Vets Affairs #: Expiry:

GP name: GP phone:

GPaddress:

Preferred method of communication

☐ Email ☐ Letter ☐ SMS ☐ Telephone

Medical history

Have there been any changes to the following? If so, please tick the appropriate boxes.

☐ Abnormal/excessive bleeding
☐ Angina
☐ Artificial heart valve
☐ Asthma
☐ Blood disorder (name below)
☐ Blood pressure (high/low)
☐ Blood thinner
☐ Bone disease (e.g. Osteoporosis)
☐ Current or past Bisphosphonate therapy
☐ Cancer
☐ Cardiac surgery/pacemaker
☐ Congenital heart defect
☐ Diabetes type 1/type 2
☐ Epilepsy
☐ Heart disease
☐ Heart murmur
☐ Hepatitis A/B/C/D
☐ HIV positive
☐ Immune deficiency
☐ Kidney/liver disease
☐ MS
☐ Nervous disorder
☐ Oral ulceration
☐ Prosthetic joints
☐ Psychiatric care
☐ Radiation/chemotherapy
☐ Reflux
☐ Rheumatic fever
☐ Steroid therapy
☐ Stroke
☐ Thyroid disorder

Medical history (continued)

Are you pregnant? ☐ Yes ☐ No If so, due date?

Any new allergies? If so, please list:

Are you taking medication (including natural supplements)? If so, please list:

Allergies

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs

☐ Other (please specify):

Dental history

Last dental visit: Is there a particular reason for your visit today?

Have you ever had a reaction or complication following dental treatment in the past? ☐ Yes ☐ No

If yes, please detail:

Is there anything else the dentist or hygienist should be aware of?

Are you suffering from any of the following?

☐ Bad appearance of teeth
☐ Bad breath
☐ Bleeding gums
☐ Difficulty chewing
☐ Discoloured teeth
☐ Dry mouth
☐ Grinding/clenching
☐ Missing teeth
☐ Loose teeth
☐ Lost filling/cavity
☐ Rapidly decaying teeth
☐ Pain in face/jaw
☐ Sensitive teeth
☐ Sounds from joint
☐ Toothache
☐ Unsatisfactory denture
☐ Worn or broken teeth

Have you ever had a sleep study and been diagnosed with sleep apnoea? ☐ Yes ☐ No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? ☐ Yes ☐ No

Has anyone ever told you that you snore? ☐ Yes ☐ No

After 6-7 hours of sleep do you wake up refreshed? ☐ Yes ☐ No

How did you find out about us?

☐ Google ☐ Website ☐ TV advert ☐ Billboard advert

☐ Other (please specify): ☐ Referred by friend/family:

On a scale of 1 -10, with 10 being very comfortable, and 1 being very anxious, how comfortable are you feeling about your appointment today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Privacy policy and signature

Any information is collected and maintained in accordance with State and Federal Privacy Legislation. A copy of our privacy policy can be obtained online from our website. I have accurately completed this medical history form to the best of my knowledge.

I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

I authorise my dentist to take images of my teeth both before and after my treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.

Patient name: Signature: Date: