Welcome to Hoppers Crossing Dental Clinic

PATIENT HISTORY SHEET

Health Information is gathered for treatment purposes only. So that this dental practice can provide the highest standard of care, please fill in this form carefully and thoroughly.

Surname: .....First Name:.....Title: (e.g. Mr/Mrs/Ms/other.....

Home Address:.....Date of Birth:.....

.....P/Code.....

Mobile:.....Home Phone:.....Work .....

Email:.....

Person responsible for Fees: SELF ☐ OTHER ☐ NAME.....CONTACT No.....

Address (if different from above).....

Emergency Contact:.....Relationship.....Contact No:.....

Medical Doctor:.....

Address:.....Pcode:.....Ph:.....

Do you have Private Health Insurance? Yes ☐ No ☐ Health Fund

How did you find out about our practice?.....

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE:

	YES	NO		YES	NO
High blood pressure	☐	☐	Depression / Anxiety	☐	☐
Heart ailment	☐	☐	Diabetes	☐	☐
Rheumatic Fever	☐	☐	Thyroid problems	☐	☐
Asthma, chest or breathing problems	☐	☐	Excessive bleeding or blood disorder	☐	☐
Heart Valve / Artificial Joint	☐	☐	Hepatitis	☐	☐
Stomach (eg ulcer, reflux) or bowel problems	☐	☐	AIDS?HIV	☐	☐
Kidney Disease	☐	☐	Bone Disorders or Diseases	☐	☐
Cancer	☐	☐	Epilepsy	☐	☐
Other.....	☐	☐			

Do you smoke? Yes ☐ No ☐ How Many?...../ day Would you like to stop? ☐ ☐

Would you like to discuss these questions in private with the dentist? ..... ☐ ☐

Have you ever had problems with dental treatment?..... ☐ ☐

Are you taking any drugs, medicines or tablets? (Please list)..... ☐ ☐

Female patients, are you pregnant?..... ☐ ☐

Do you have any allergies?..... ☐ ☐

List any medicines or products you are allergic to (e.g. Penicillin, latex).....

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE

DENTAL UPDATE:

1. Do you have any dental pain / discomfort? YES ☐ NO ☐
2. Do your gums bleed when you brush / floss? YES ☐ NO ☐
3. Are you happy with the colour and look of your teeth? YES ☐ NO ☐
4. Would you like to discuss options to improve your smile? YES ☐ NO ☐

SNORING/SLEEP APNOEA:

Dentists have an important role in the screening and management of sleep disorders, including snoring and sleep apnoea.

1. Is snoring a problem for you or your partner? YES ☐ NO ☐
2. Do you wake feeling well and refreshed in the morning? YES ☐ NO ☐
3. Do you get sleepy during the day? YES ☐ NO ☐
4. Has anyone heard you stop breathing or gasp during sleep? YES ☐ NO ☐

I have completed the questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (xrays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

Signed.....Date.....

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED