TRINITY BEACH DENTAL
Dr Tony Ormes

PATIENT MEDICAL HISTORY

These details provide us with information required for your optimal dental treatment and oral health care.
Your Privacy & Confidentiality will be respected at all times.

Surname:	First Name:
Title: Mr / Mrs / Miss / Mst / Ms / Dr /	Occupation:
Date of birth:	Address:
Home Phone:	Postcode:
Mobile Phone:	Work Phone:
Email:	Preferred Contact:
Private Health Insurance:	Home / Mobile /Work / Email / SMS

Have you had any of the following? (tick)

Heart problems	☐	Diabetes	☐
Blood pressure	☐	Asthma	☐
Artificial joints	☐	Epilepsy	☐
Rheumatic fever	☐	Hepatitis ABCDE	☐
Circulatory problems	☐	Liver or Kidney problems	☐
Radiation treatment	☐	Osteoporosis	☐
Excessive bleeding/bruising	☐	Allergies to anaesthetics	☐
Mental illness	☐	Allergies to penicillin	☐
Sinus trouble	☐	Allergies to medications	☐
Cancer History	☐	Allergies to latex	☐
Anaemia or other blood disorder	☐	Other _____	☐

Do you smoke? Yes / No

Are you pregnant ? Yes / No If yes when are you due?

Are you currently taking any medications? Yes / No

If yes, please list: _____

_____

_____

Name of your doctor: _____ Phone no: _____

Emergency Contact /relationship : _____ Phone no: _____

Consent for treatment

I hereby authorise Dr Tony Ormes to take x-rays, study models, photographs & other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me & to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives & other medication as necessary. I fully understand I can ask for a full recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf & on behalf of my dependents. I understand that payment is due at the time of service.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____

Relationship to patient: _____ Dentist Signature: _____

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PATIENT DENTAL HISTORY

What is the main reason for your visit today?

……

Does your jaw click or hurt?	☐	Yes	☐	No
Do you feel you grind or clench your teeth?	☐	Yes	☐	No
Do you wear a night guard/splint?	☐	Yes	☐	No
Have you ever had gum disease?	☐	Yes	☐	No
Do you think you have occasional bad breath?	☐	Yes	☐	No
Do your gums ever bleed when you brush?	☐	Yes	☐	No
Do you experience sensitivity to hot or cold?	☐	Yes	☐	No
Does floss ever tear between your teeth?	☐	Yes	☐	No
Does food pack between your teeth?	☐	Yes	☐	No
Do your teeth ever hurt when you bite hard?	☐	Yes	☐	No
Are you concerned about missing teeth or gaps?	☐	Yes	☐	No
Are you concerned about the appearance of your teeth?	☐	Yes	☐	No
Are you nervous about dental treatment?	☐	Yes	☐	No

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 ☐ More than a year ago

Information regarding your dental history and previous treatment may assist us in diagnosis and treatment planning.

Would you like us to obtain a copy of your radiographs and treatment records from your previous dentist?

Yes / No

Name of previous Dental Practice .....

How did you hear about our practice?

Yellow Pages / Local Directories / Signage / Website / Advertisement / Facebook / Friend or Other

.....

As we like to thank current patients or other healthcare providers for their kind referrals, if you were referred please provide the name of the person who referred you.

Name of Referrer .....