

NEW PATIENT MEDICAL / DENTAL HISTORY FORM

Please note that all information on this medical/dental form will remain strictly confidential. Please complete in **CAPITAL LETTERS**.

Surname		Given Names	Mr/Mrs/Ms
Date of Birth		Occupation	
Phone (H)	<input type="checkbox"/>	Home Address	
Phone (W)	<input type="checkbox"/>		
Phone (Mobile)	<input type="checkbox"/>		
		Postcode	
Email address			
Emergency contact (please provide name and phone number):			

To complete only if the patient is under 18 years old

Guardian Name & Contact Address/Phone Details	
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Referral Information

<input type="checkbox"/> Internet/Website <input type="checkbox"/> Walked past <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Village Voice <input type="checkbox"/> Dentist Dr. _____	
<input type="checkbox"/> Patient (please provide name so that we can thank them) _____	

MEDICAL HISTORY

Name of your GP:	Your Doctor's Phone No.
Your Doctor's address:	

Have you ever had any of the following? Please tick those that apply:

<input type="checkbox"/> Anaemia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumours
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ AIDS	<input type="checkbox"/> Psychological Disorders
Are you pregnant? If yes, how many months?		

Have you had any serious illnesses in the last 2 years? If yes, please provide more information.	
Are you currently taking any medications or tablets regularly? If yes, please provide more information.	
Are you taking or have you taken any Bisphosphonate Drugs?	
Do you have any allergies to Penicillin or other drugs? If yes, please provide more information.	
Do you suffer from sleep apnoea?	
Is your blood pressure normal, high or low?	
Do you smoke? If so how many per day?	

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (please tick as many as it applies)

- Sensitivity to hot or cold
- Staining of your teeth
- Bleeding gums
- Head/neck ache
- food trapping between your teeth
- discoloured fillings
- bad breath
- grinding or clenching of your teeth
- clicking/pain in the jaw joints
- roughness of existing fillings
- sensitivity when eating

Are you concerned with: (please tick as many as it applies)

- Existing crowns, bridges or dentures
- Tooth clean techniques (e.g. Brushing / Flossing)
- Crooked teeth
- Missing teeth
- Ability to eat your smile
- Silver fillings
- Gaps between your teeth
- Discolouration of your teeth
- Previous dental treatment

What is the main purpose of your visit today?

How long since your last dental visit? _____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Have you ever had or require the following for dental treatment?

- Gas (Nitrous oxide-laughing gas)
- Intravenous sedation
- General Anaesthesia

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires as minimum 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of \$50.00 could be incurred if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment.

x _____
Patient Signature

Date of signature

DENTISTS

Dr. Christopher Ho

Dr. Martin Nash

Dr. Jemima Neale

Dr Anthony Mak

CONTACT US

T: 98105507

E:info@dentistrybydesign.com.au

WE ARE LOCATED AT

45 Rowntree Street

Balmain NSW 2041

SURGERY HOURS

Monday 8.00am - 5.00pm

Tuesday 8.00am - 5.00pm

Wednesday 8.00am - 5.00pm

Thursday: 8.00am - 6.00pm

Friday: 8.00am - 4.00pm

Saturday: 8.00am - 1.00pm

For more information on any of our services and frequently asked questions on dental health please visit us on the Web at:

www.dentistrybydesign.com.au

Your First Visit at Dentistry by Design



On your first visit to **DENTISTRY by design**, we will carry out a comprehensive examination and survey of your dental health.

This enables us to gather the information we need for complete diagnosis and treatment planning, helping us to maintain your smile for life.

If you have any oral health queries in the meantime, please do not hesitate to contact us or visit our website dentistrybydesign.com.au

Service Features and Benefits

Your dental health and medical history

- identifying any conditions, allergies or medications
- identifying any habits or risk factors
- identifying any special needs or concerns

This helps us to provide you with dental care that's comprehensive, effective, comfortable and safe. If necessary, we will consult with your GP or specialist.

Full mouth charting

- enabling a complete diagnosis of your mouth
- addressing health, function and aesthetics
- looking at your mouth and the supporting structures of your teeth as a whole

Proper diagnosis enables us to better plan your treatment and continuing care, establishing priorities for the best long-term results.

Oral health examination

- checking for any unhealthy lesions in the glands, jaw and soft tissue
- checking for oral cancer, which accounts for 4% of all cancers

As with any medical condition, early detection is crucial for successful treatment. We can refer you to a specialist to further investigate or treat any problems we identify.

Periodontal charting

- checking the supporting structures of your teeth—the gums and bones
- checking for various forms of gum and bone disease, such as gingivitis and periodontitis

One in four adults loses teeth to periodontal disease. We'll explain the essential relationship between your oral health and your overall health.



Occlusal analysis

- identifying habits—such as teeth clenching or grinding—that may affect your teeth and restorations
- documenting the alignment of your teeth and assessing bite forces that may affect restorations
- protecting the longevity of your teeth and restorations

Smile assessment

- assessing the appearance of your teeth and smile
- assessing your gum height and other soft tissue
- discussing what you like and dislike about your smile
- discussing your expectations and desires
- explaining how your smile can be enhanced

Shade assessment

- assessing the shade of your teeth and identifying your desired shade
- assessing the potential benefits of teeth whitening
- identifying shade guides for any restorative work, such as veneers, crowns or composite restorations

Imagery

- intra-oral and digital camera imagery showing you what we see
- demonstrating our concerns and revealing more detail
- visually recording the teeth, lips and smile

X-rays

- x-rays may be taken to provide a more detailed view of any areas of concern revealing hidden tooth decay, such as under restorations or between the teeth
- revealing any other hidden conditions
- revealing un-erupted teeth, such as wisdom teeth
- revealing any abnormalities and hidden conditions
- revealing the pathology of the jaw and any bone and tooth loss

Early detection and intervention enable us to prevent any future problems and discomfort.

TMJ assessment

- detecting abnormalities and dysfunctions with the jaw and jaw joint which can reveal causes of some headaches

Orthodontic considerations (if required)

- referring for orthodontic treatment, for aesthetic or functional reasons
- in some cases, this is required before preparing and proceeding with the treatment plan

Upper and lower study models (if required)

- providing a diagnostic record of your existing teeth and bite
- monitoring wear and helping to plan and present your treatment
- helping to monitor and preserve your teeth and bite for the long-term
- providing a reconstructive guide in case of an accident



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