**Medical and Dental History Form**

Welcome to **Rainbow Dental Practice!**

We assure you a caring and gentle environment and our complete attention to make your visit comfortable and relaxing. To assist in determining your treatment needs, please fill **both sides** of this form.

# Contact Details

**Title** (Mr, Mrs, Miss, Ms, and Dr) ................

**Surname** ………...................................................................... First name .......................................................................

**Preferred name** ……............................................................... Date of Birth ............. / …............ / ……..........

**Home address** ........................................................................ Suburb …...………………………. Postcode ....................

**Telephone** Home .................................................................... Mobile ..............................................................................

**Occupation** .............................. Company …………….………... Email ............................................................................

**Emergency contact** ….............................. Relationship to patient .......................... Telephone ......................................

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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**Insurance Details:**

 For Children 2-17 bulk billing under CDBS Medicare NoSeq No

 I have Private Health Insurance with Dental Cover.

Insurance Name ……….………………….………….…. Member No ……….………………. Seq No …...

(Rainbow Dental is a preferred provider for **CBHS Health Funds**)

**For patients under 16 only:**

Person responsible ................................................ Relationship to patient ........................ Mobile ……………………….

Address ................................................................................................................... Postcode..........................................

**How did you hear about Rainbow Dental Practice?** .....................................................................................................

**How would you like us to contact you?**  Mobile  SMS  Email  Mail  Other…………………..…………….…

**Would you like us to contact you about Special Offers?**  Yes No

**Dental Questionnaire**

When was your last visit to a dentist? …………………………………….. Reason ……………………………………. ….…

Have you made this appointment for a  Routine Check-Up  Emergency Treatment?

 Continue Unfinished Treatment  Second Opinion  Other (Specify) …….…………….……………….….

**Are you concerned about or experiencing any of the following?** (Please tick those that apply)

 Food trapping between your teeth Sensitivity to hot or cold  Ability to eat

 Existing crowns, bridges or dentures Your smile  Oral hygiene

 Clicking/ pain in the jaw joints  Bad breath  Bleeding gums

 Grinding or clenching of your teeth  Gaps between your teeth  Crooked teeth

 Missing teeth  Discolouration/ Staining  Other (Specify) …………………………….

# Medical Questionnaire

**Medical practitioner -** Name……………………………….......................... Suburb...........................................................

**Past / Present medical conditions. (Please tick those that apply)**

|  |  |  |
| --- | --- | --- |
| Are you receiving any medical treatment at present? **** Yes  Have you had any serious or long standing illness?  Yes  Have you ever been hospitalised?  Yes  Have you had heart or joint replacement surgery?  Yes  Have you stopped taking any medication in the last week?  Yes  Are you allergic to any medication or antibiotics?  Yes  Are you allergic to latex?  Yes  Had cosmetic or other surgery to mouth, jaw, lips or face?  Yes  Details……………………………………………………………………………………………………………………………..….  **Have you ever had any of the following? (Please tick those that apply)** | | |
|  Anxiety / Depression |  Epilepsy |  High blood pressure |
|  Asthma / Breathing problems |  Excessive bleeding |  HIV / AIDS |
|  Cancer |  Heart problems |  Osteoporosis |
|  Diabetes |  Hepatitis |  Rheumatic fever |

Details……………………………………………………………………………………………………………………..………….

**Are you on any of the following medications? (Please tick those that apply)**

 Blood thinning (Aspirin / Warfarin / Plavix)   Cortisone (Prednisolone)  Diabetes (Diabex)

 Osteoporosis (Fosamax / Actonel)  Thyroid (Thyroxin / Oroxin)  Vitamins or Herbal Supplements

 Psychiatric (Anti-depressants / Lithium / Anti-anxiety / Sleeping tablets)

**Female patients:** Are you pregnant? No  Yes How many months? .....................................

**Smokers:** How many cigarettes do you smoke per day? ..................... Would you like to stop?  No  Yes

# Privacy Policy

The information collected by our practice will be used for the purpose of providing treatment to you. Personal information will be used to address accounts to you, process payments and write to you about our services and any issues affecting your treatment.

* We may disclose your health information to other health care professionals, or require it from them if it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.
* Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time. Fees may apply.
* If any information we have about you is inaccurate, you may ask us to alter our records accordingly.
* Your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice without your prior written consent. If you have any queries or concerns, please do not hesitate to raise these concerns with our practice.

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# Patient Signature Date