Bite dental studios

Medical History Form 1

To allow us to provide you with the most successful dental treatment, providing your medical history is important.

Your details

Mr/s etc | First name | Preferred name | Last name

Date of birth | Email

Phone | Mobile

Preferred contact method: email sms phone

Address | Suburb | Postcode

Health fund | Your doctor

Doctor's phone | Doctor's address

Contact name (in case of emergency) | Contact phone

How did you hear about Bite Dental?

friend email website google advert promo

Were you referred? If yes, by whom?

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this. (please tick)

General health

Have you been treated by a doctor or hospitalised for any illness in the last 2 years?

Yes (describe)

Are you taking any medication (prescribed or over-the-counter)? eg asprin, blood thinners, steroids, bisphosphonates

Yes (describe)

Are you taking any natural remedies? eg supplements, vitamins, St John's wort, lemon water, grapefruit

Yes (describe)

Do you normally require antibiotic cover before dental treatment?

Yes (describe)

Have you had any abnormal reactions to local or general anaesthesia?

Yes (describe)

Do you have any allergies? (including latex or drugs)

Yes (describe)

continued over

Do you smoke?

Yes—how many per day?

(Females) Are you pregnant?

Yes—how many weeks?

Do you have, or have you ever had any of the following conditions? If yes, please indicate

Yes (please tick)

- Anaemia, leukaemia or other blood disease
- Anxiety or depression
- Arthritis
- Asthma
- Automimmune condition
- Bisphosphonates and other bone medications
- Bleeding (excessive)
- Blood pressure ○ high or ○ low (please tick)

Yes (please tick)

- Bronchitis, emphysema or other lung disease
- Cancer
- Cardiac pacemaker
- Diabetes
- Epilepsy
- Heart disorder / disease
- Heart surgery
- Hepatitis, or close contact
- HIV / Aids, or close contact
- Kidney disease
- Liver disease

Yes (please tick)

- Prosthetic implant eg artificial hip
- Radiation / chemo therapy
- Rheumatic fever / endocarditis
- Steroid therapy
- Stomach or digestive condition / reflux
- Stroke
- Thyroid disease
- Transplanted organ or marrow
- Tuberculosis

Any other conditions? (please list)

Your visit today

When was your last dental check-up?

Do you have a particular concern (eg sensitive teeth, bleeding gums)?

Is there anything you'd like your dentist to address today?

How nervous or anxious does visiting the dentist make you feel? (please circle)

not at all 1 2 3 4 5 6 7 8 9 10 extremely

How happy are you with your smile? (please circle)

not at all 1 2 3 4 5 6 7 8 9 10 extremely

Is there anything you'd like to change about your smile?

We take your privacy seriously so we won't disclose any information unless you have authorised us to. For full details check out the *Privacy Statement* on bitedental.com.au or ask reception for a copy.

This is a true and accurate medical history and I understand and accept the Bite Dental Studios privacy policy:

Signature

Date

Dentist