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: Mr
First name: First name
Preferred name: Preferred name
Last name: Last name

Date of birth: 1 January Year of birth
Email: Email address

Phone: Phone number
Mobile: Mobile number

Preferred contact method: ☑ email ☐ sms ☐ phone
Click boxes to the left to select your preferred contact methods

Address: Address
Suburb: Suburb
Postcode: Postcode

Health fund: Health fund
Your doctor: Your doctor

Doctor's phone: Doctor's phone number
Doctor's address: Doctor's address

Contact name (in case of emergency): Contact name
Contact phone: Contact's phone number

How did you hear about Bite Dental?
☐ friend ☐ email ☐ website ☐ google ☐ advert ☐ promo
Click boxes above to select how you heard about Bite Dental

Were you referred? If yes, by whom?: Who referred you?

☐ 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) Describe treatment or hospitalisation

Are you taking any tablets or medicines (prescribed or over-the-counter)?
☐ Yes (describe) Describe natural remedies

Are you taking any natural remedies (eg grapefruit, St John's wort)?
☐ Yes (describe) Describe natural remedies

Do you normally require antibiotic cover before dental treatment?
☐ Yes (describe) Describe antibiotic cover required

Have you had any abnormal reactions to local or general anaesthesia?
☐ Yes (describe) Describe abnormal reactions

Do you have any allergies? (including latex or drugs)
☐ Yes (describe) Describe allergies

continued over

Do you smoke?

☐ Yes—how many per day? Number per day

(Females) Are you pregnant?

☐ Yes—how many weeks? Number of weeks pregnant

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
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding (excessive)
- ☐ Blood pressure (high or low)
- ☐ Bronchitis, emphysema or other lung disease
- ☐ Cancer
- ☐ Cardiac pacemaker
- ☐ Diabetes

Yes (please tick)

- ☐ Epilepsy
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Heart disorder/disease
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hepatitis, or close contact
- ☐ HIV/Aids, or close contact
- ☐ Nervous condition
- ☐ Prosthetic implant eg artificial hip

Yes (please tick)

- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Shortness of breath
- ☐ Steroid therapy
- ☐ Stomach or digestive condition
- ☐ Stroke
- ☐ Transplanted organ or marrow

Click boxes above to select any conditions you may have, or have had

Any other conditions? (please list)

Describe any other conditions

Your visit today

When was your last dental check-up?

Your last check-up

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

Particular concerns

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

What should be addressed today

Are you happy with your smile?

Are you happy with your smile

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

Is there anything you'd like to change

We take your privacy seriously so we won't disclose any details 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

Click to print and sign document

Date

1 January 2011

Dentist