**WELCOME TO OPULENT DENTAL**

**PATIENT PERSONAL & MEDICAL QUESTIONNAIRE**

**PRIVATE & CONFIDENTIAL**

**Do you require assistance in completing this form?**

**If so please proceed to reception for assistance**

***Please answer these questions as completely as possible. It will greatly assist us to provide the best dental treatment for you. (PLEASE NOTE THERE ARE 3 PAGES TO THIS MEDICAL HISTORY)***

Name

(Mr/Mrs/Miss/Ms/Dr/Other)………………………………………………………………….............................

(First names) (Family name)

Address……………………………………………………………..................................................................

Suburb………………………………………………………………………………..Postcode...……………….

Date of Birth……..………………..........Email……………………..............................................................

Phone (Home) ...…………............Phone (Work) ...........................Phone (Mobile)……………..........

Occupation …………………………….................. Employer …………………………………………………

Emergency Contact........................................... Relationship.............................. Phone ………………..

Person responsible for payment of accounts.............………………… ……………………....................

Which Health Fund do you belong to?………………………………………………….................................

Are you a Pension Card or Health Care Card Holder?............................................................................

Whom may we thank for recommending you to our practice?...............……………………......................

What is your previous Dental Clinic?......................................................................................................

***The state of your health may have a very significant effect on your dental care.***

***Please answer these questions fully or discuss them with your dentist:***

Y N

I have private and confidential medical matters which I wish to discuss with the dentist 

Are you receiving any medical treatment at present? .................................................... 

Name of your medical practitioner / specialist .......................…………………………….……...................

* **Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.**
* **Please provide details (*including dose and frequency*) of any medicine or medication that you are currently taking, or have been taking recently. This should include:**

**PLEASE TURN PAGE OVER**

 Aspirin..............................................................................................................................................

Oral Contraceptive…………………………………………………………………………………………….

 Warfarin, Heparin OR other blood thinning medicine.......................................................................

 Hormone Replacement Therapy.......................................................................................................

 Cortisone or Steroids..........................................................................................................................

 Medication for depression (MAOIs, SSRIs or Tricyclics).....................................................................

 Treatment for osteoporosis (Bisphosphonates, Prolia).......................................................................

 Any other prescription Medication.......................................................................................................

 Any herbal or naturopathic medications.............................................................................................

 Any ‘over the counter’ medications.....................................................................................................

***If you are in any doubt about your medication, please bring the bottle or packet(s) to the practice to show the dentist.***

**Please indicate YES or NO if you have the following:**  **Y N** **Y N**

Rheumatic Fever  Hepatitis, jaundice **OR** liver disease 

Any heart (cardiac) complaint/treatment  Thyroid disease (Including goitre) 

Cardiac pacemaker  Snoring **OR** Sleep Apnoea 

Heart valve replacement  Neck/Jaw or Shoulder damage or pain 

High Blood Pressure  Low Blood Pressure 

Urinary tract/Kidney disease  Anti-coagulant (blood thinning) 

Epilepsy (Fits) Transplanted organ/bone marrow/stem cells 

Blood disorders  Tuberculosis (TB) 

Excessive bruising or bleeding  Asthma/bronchitis/lung conditions 

Osteoporosis or low bone density  Any nervous system disorder 

Diabetes **OR** family history of diabetes  Anxiety **OR** Depression 

Joint replacement surgery  Gastroesophageal reflux disease (GORD) 

Chemotherapy/Radiation therapy  Inflammatory Bowel disease 

Treatment for cancer (type/region) Using or Taking illicit drugs 

**ALLERGIES TO- Y N**

Penicillin or other Antibiotics **(if YES please specify)**………………………….

Food………………………………………………………………………………..……….

Latex…………………………………………………………………….………………….

Chemicals…………………………………………………………….……………………

Other…………………………………………………………………….………………….

**PLEASE TURN PAGE OVER**

***Please indicate YES or NO if you have ever had any of the following:***

Do you currently smoke? Y N

Have you ever required any treatment for smoking related diseases or conditions? Y N

Do you suffer from any illness not listed above or carry any infectious disease? Y N

If yes, please provide details.......................................................................................................

**FEMALES:** Are you pregnant? Y  N  if yes, when are you due?................................

Are you breastfeeding? Y N 

**DECLARATION:**

* In signing this form I acknowledge that this represents an accurate medical history.
* I will advise my dentist of any changes to my medical history in the future.
* I understand that all medical details will be treated with complete professional confidentiality.

Patient Signature ……………………………………….............................. Date ……………………………

(Parent or guardian if under 18 years)

**We hope that you are comfortable and have a pleasant experience here at Opulent Dental. Thank you for choosing our practice to satisfy your dental needs ☺**