MEDICAL HISTORY

In order to provide you with the highest standard of dental care, Oasis Dental needs to collect personal information and details from you. Please complete this accurately so that we may be able to provide the best and safest care to you.

Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you may be asked additional questions relating to your responses where it will help our clinicians better your care.

For information about your rights relating to the collection of information visit: http://goo.gl/YROjy3

YOUR DETAILS

TITLE Mr / Mrs / Ms / Miss / Master / Dr

DOB _____

FIRST NAME _____

SURNAME _____

ADDRESS _____

SUBURB _____

POSTCODE _____

MOBILE PH _____

HOME PH _____

EMAIL _____

OCCUPATION _____

CONTACT PREFERENCE FOR APPOINTMENTS SMS • TELEPHONE • EMAIL

EMERGENCY CONTACT PERSON (NAME/NUMBER) _____

DO YOU HAVE DENTAL INSURANCE? Y • N

NAME OF FUND? _____

DENTAL HISTORY

DO YOU FEEL NERVOUS ABOUT DENTAL TREATMENT? N (1 • 2 • 3 • 4 • 5) Y

WHEN WAS YOUR LAST DENTAL APPOINTMENT? _____

REASON FOR TODAY'S VISIT? _____

DO YOU GRIND OR CLENCH YOUR TEETH? _____

HOW DID YOU HEAR ABOUT US?

(PLEASE TICK)

O Walked past the practice

O Google

O Health Fund

O Instagram

O Facebook

O Recommended by someone
If so, who? (We'd love to thank them!)

_____

MEDICAL HISTORY

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MEDICAL DOCTOR'S NAME _____ PHONE # & PRACTICE NAME _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS / INJECTIONS? (INCLUDING HERBAL SUPPLEMENTS) Y • N

ARE YOU CURRENTLY UNDERGOING ANY MEDICAL TREATMENT? Y • N

HAVE YOU HAD ANY MAJOR SURGERIES / ILLNESSES / DISEASES IN THE PAST? Y • N

HAVE YOU BEEN ADVISED TO TAKE ANTIBIOTICS BEFORE DENTAL APPOINTMENTS IN THE PAST? Y • N

DO YOU HAVE ANY ALLERGIES? (E.G. LATEX, ANAESTHETIC, MEDICATIONS/DRUGS, FOODS, PLANTS) Y • N

ARE YOU A SMOKER? Y • N # PER DAY _____

ARE YOU PREGNANT OR BREAST FEEDING? Y • N HAVE YOU HAD BOTOX BEFORE? Y • N

HAVE YOU HAD ANY OF THE FOLLOWING?

High / Low blood pressure Y • N
Rheumatic fever / Rheumatic heart disease Y • N
Heart valve / Pacemaker Y • N
Other heart conditions
_____
Stroke Y • N
Hepatitis Y • N
HIV / AIDS Y • N
Blood / Bleeding disorders Y • N
Asthma Y • N
Sinus issues Y • N
Other respiratory conditions
_____

Sleep apnoea Y • N
Diabetes Y • N
Stomach ulcers / Indigestion / Acid reflux Y • N
Fainting / Epilepsy / Seizures Y • N
Cancer Y • N
Radiation / Chemotherapy Y • N
Artificial joints Y • N
Osteoporosis / Other bone disorders Y • N
Depression / Anxiety / ADHD Y • N

Any other conditions / diseases
_____
_____

Dental photographs will often be taken to assist in the provision of your treatment. Our dentists are also involved in research and teaching. Do you consent for your photos to be shared **(cross if you decline)**:

- With other dentists and oral health professionals (print/email/online closed forums)
- In the education of other patients
- On public social media – Facebook / Instagram

I have completed the above to the best of my knowledge and all information collected will be treated in confidence. I understand that payment is to be made at the time of my appointment. I understand that if I need to reschedule my appointment, I will give Oasis Dental Studio 48 hours notice. If I fail to give 48 hours notice, a cancellation fee may apply.

Patient Name _____ Date _____

Patient Signature _____