

# New patient Medical and dental history

Moranbah Dental



WWW.MORANBAHDENTAL.COM.AU

Date:

## Patient details

Title: Mr Mrs Ms Dr Other:

Surname:

Given name:

D.O.B:

Residential address:

Suburb:

State:

Postcode:

Postal address (if different):

Home phone:

Work phone:

Mobile:

Email:

We will send you email communications from time to time, including our regular newsletter and offers.  
Please tick this box if you don't wish to receive communication from us.

Occupation:

Company:

Emergency contact:

Phone:

Relation:

Private health insurer:

Member #:

Patient #:

Medicare #:

Ref #:

Expiry:

Vets Affairs #:

Expiry:

GP name:

GP phone:

GP address:

## Preferred method of communication

Email

Letter

SMS

Telephone

## Medical history

Please tick if you have ever had any of the following:

Abnormal/excessive bleeding

Angina

Artificial heart valve

Asthma

Blood disorder (name below)

Blood pressure (high/low)

Blood thinner

Bone disease (e.g. Osteoporosis)

Current or past

Bisphosphonate therapy

Cancer

Cardiac surgery/pacemaker

Congenital heart defect

Diabetes type 1/type 2

Epilepsy

Hearing impairment

Heart disease

Heart murmur

Hepatitis A/B/C/D

HIV positive

Immune deficiency

Kidney/liver disease

Neurological disorder

Oral ulceration

Prosthetic joints

Psychiatric care

Radiation/chemotherapy

Reflux

Rheumatic fever

Steroid therapy

Stroke

Thyroid disorder

Other condition(s) (name below)

## Medical history (continued)

Are you pregnant?      Yes      No      If yes, how many months?  
Are you Aboriginal or Torres Strait Islander?      Yes      No  
Are you taking medication (including natural supplements)? If yes, please list:

Are you a smoker?      Yes      No      If yes, how often?

### Allergies

Aspirin      Iodine      Latex      Penicillin      Sulpha drugs  
Other (please specify):

## Dental history

Last dental visit:      Is there a particular reason for your visit today?

Have you ever had a reaction or complication following dental treatment in the past?      Yes      No  
If yes, please detail:

Is there anything else the dentist or hygienist should be aware of?

Do you generally feel anxious about seeing your dentist and/or hygienist?  
Yes - extremely      Yes - very      Yes - somewhat      No - not at all

### Are you suffering from any of the following?

|                         |                    |                        |                        |
|-------------------------|--------------------|------------------------|------------------------|
| Bad appearance of teeth | Discoloured teeth  | Lost filling/cavity    | Toothache              |
| Bad breath              | Dry mouth          | Rapidly decaying teeth | Unsatisfactory denture |
| Bleeding gums           | Grinding/clenching | Pain in face/jaw       | Worn or broken teeth   |
| Difficulty chewing      | Missing teeth      | Sensitive teeth        |                        |
|                         | Loose teeth        | Sounds from joints     |                        |

Have you ever had a sleep study and been diagnosed with sleep apnoea?      Yes      No  
If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy?      Yes      No  
Has anyone ever told you that you snore?      Yes      No  
After 6-7 hours of sleep do you wake up refreshed?      Yes      No

### How did you find out about us?

Google      Social Media      Bupa store      TV      Radio      Print ad      Billboard      Flyer  
Word of mouth      Signage      Other (please specify):

## Privacy policy and signature

All personal information collected by Bupa Dental Corporation is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information. You can view the policy online at <https://www.dentalcorp.com.au/australian-privacy-policy/>.

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient/Legal guardian name:

Signature:

Date:

OFFICE USE ONLY.

Form checked by \_\_\_\_\_ Data keyed by \_\_\_\_\_ Keying checked by \_\_\_\_\_ Form scanned by \_\_\_\_\_