

# Patient Medical & Dental Information



At Lifelong dental we strive to provide you with the highest possible Dental Care.  
Filling in this form as accurately as possible will help us to achieve this.  
Please be aware that we send appointment reminders via SMS.

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## Patient Details

Title:	<input type="text"/>	Surname:	<input type="text"/>	Given Name(s):	<input type="text"/>
Preferred Name:	<input type="text"/>	Date of Birth:	<input type="text"/>		
Residential/Postal Address:	<input type="text"/>				
Suburb:	<input type="text"/>	Post Code:	<input type="text"/>		
Home Phone:	<input type="text"/>	Mobile:	<input type="text"/>		
Email Address:	<input type="text"/>	<input type="checkbox"/>	Please tick this box if you don't wish to receive email communications like newsletters from Lifelong Dental		
Emergency Contact Name:	<input type="text"/>	Phone:	<input type="text"/>		
Person responsible for fees:	<input type="text"/>				
Private Health Fund Name:	<input type="text"/>				
Who is your medical practitioner?	<input type="text"/>	Phone:	<input type="text"/>		

## How did you hear about us?

<input type="checkbox"/>	Referred by family member, friend or colleague. Whom may we thank?	<input type="text"/>						
<input type="checkbox"/>	Website	<input type="checkbox"/>	Google	<input type="checkbox"/>	Social Media	<input type="checkbox"/>	Other. Please specify:	<input type="text"/>

## Medical Information

We appreciate your time and effort in answering the following questions fully. They are very important in ensuring that we diagnose any dental concerns in association with your overall medical health.

Many medical conditions influence dental health and conversely many chronic dental diseases impact on the function of major organs, general health and wellbeing.

Are you under the care of a Doctor at the moment for any serious medical condition? If yes, please specify:

## Please indicate and detail if any of the following apply to you now or ever in the past

	NEVER	PAST	PRESENT		NEVER	PAST	PRESENT
Are you a smoker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder/Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure (High or Low)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Reflux Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Auto Immune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart or Vascular Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Females: Are you, or could you possibly be pregnant now?  If yes, how many months?

Please list any over the counter or prescribed medications that you take:

Have you ever had an allergic reaction to any medications or procedures? ☐ Yes ☐ No If yes, please provide details:

Have you ever had any serious health issues? ☐ Yes ☐ No If yes, please provide details:

Have you ever had any of these specific class medicines: Bi-phosphonates, Neuromuscular Inhibitors, Dermal Fillers or Botox?  
☐ Yes ☐ No If yes, please specify:

## Dental Information

When was your last Dental visit?  What Treatment did you have?

Have you ever had any Orthodontic treatment? ☐ Yes ☐ No Do you use a dental splint? ☐ Yes ☐ No

**Have you had any of the following?**

	Yes	No		Yes	No
Toothache	<input type="radio"/>	<input type="radio"/>	Problems chewing your food	<input type="radio"/>	<input type="radio"/>
Sensitive Teeth (to hot/cold/pressure)	<input type="radio"/>	<input type="radio"/>	Problems opening or closing your jaw	<input type="radio"/>	<input type="radio"/>
Lost filling or Cavity	<input type="radio"/>	<input type="radio"/>	Clenching or Grinding your teeth	<input type="radio"/>	<input type="radio"/>
Decaying Teeth	<input type="radio"/>	<input type="radio"/>	Pain in your Face or Jaw	<input type="radio"/>	<input type="radio"/>
Worn or broken teeth with sharp edges	<input type="radio"/>	<input type="radio"/>	Clicking or Popping Jaw	<input type="radio"/>	<input type="radio"/>
Bleeding Gums	<input type="radio"/>	<input type="radio"/>	Snoring or Sleep Apnoea	<input type="radio"/>	<input type="radio"/>
Loose Teeth	<input type="radio"/>	<input type="radio"/>	Morning Headaches	<input type="radio"/>	<input type="radio"/>
Missing Teeth or Gaps	<input type="radio"/>	<input type="radio"/>	Dry Mouth	<input type="radio"/>	<input type="radio"/>
Discoloured Teeth or Fillings	<input type="radio"/>	<input type="radio"/>	Halitosis (bad breath)	<input type="radio"/>	<input type="radio"/>
Loose Denture	<input type="radio"/>	<input type="radio"/>	Any other dental issues (please specify)	<input type="radio"/>	<input type="radio"/>
Unsightly appearance	<input type="radio"/>	<input type="radio"/>	<input type="text"/>		

What is the purpose of today's visit?

## Privacy and Consent

- Please be assured any information is collected and maintained in accordance with State and Federal Privacy Legislation. If you would like any further information about how we use and protect your personal information, please ask our staff for "personal Information, Privacy and your Dentist" document.
- I have accurately completed this medical history form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. We do not offer credit for treatment at Lifelong dental however we do recommend a number of agencies that may offer financial assistance. Please ask our friendly staff members.
- I authorise my dentist and dental staff at Lifelong dental to take images of my teeth and face for clinical, educational and promotional purposes, while keeping my identity anonymous to all persons except staff at Lifelong dental ☐ YES ☐ NO
- I understand and accept that Lifelong dental requires a minimum of 2 working days' notice for cancelling or rescheduling appointments. All appointments that are unattended will be charged a cancellation fee.

Patient/Parent/Legal Guardian Name:

Signature:  Date: