Lifetime Dental Health Group

The breath of fresh air in dentistry

Health History Form

So we can ensure we are looking after your needs, **please complete the following questionnaire:**

Surname: (Mr/ Mrs/ Miss/ Ms/ Dr)	First name:
Date of Birth:	Address:
Mobile:	Suburb: Postcode:
Home phone:	Email:
Work phone:	Name of person responsible for fees, if not self: Relationship to patient:

Recommended by: _____

Purpose of visit: _____

Dental insurance company: _____

Is another member of your family a patient at our office: ☐ Yes ☐ No Name: _____

Have you had any of the following?

Heart Problems	☐ Yes	☐ No	Allergies to Anaesthetics	☐ Yes	☐ No
Blood Pressure	☐ Yes	☐ No	Allergies to Penicillin	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Allergies to Medications	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Allergies to Latex	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Anaemia or Other Blood Disorders	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Excessing Bruising	☐ Yes	☐ No	Hepatitis A B C D E	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Liver or Kidney Problems	☐ Yes	☐ No
Tumor History	☐ Yes	☐ No			

Are you currently taking any medications? ☐ Yes ☐ No

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If 'yes', please list: _____

Have you experienced any of the following:

Does your jaw click or hurt?	☐ Yes	☐ No	Do you smoke?	☐ Yes	☐ No
Do you feel you grind your teeth?	☐ Yes	☐ No	Do you think you have occasional bad breath?	☐ Yes	☐ No
Have you ever had orthodontic treatment?	☐ Yes	☐ No	Do your gums ever bleed when you brush your teeth?	☐ Yes	☐ No
Do you wear a night guard?	☐ Yes	☐ No	Do you experience sensitivity with hot/cold?	☐ Yes	☐ No
Have you ever had gum disease?	☐ Yes	☐ No	Does floss ever tear between your teeth?	☐ Yes	☐ No
Have you ever had your bite adjusted?	☐ Yes	☐ No	Does food get jammed between your teeth?	☐ Yes	☐ No
Do you bite your lips or cheek often?	☐ Yes	☐ No	Do your teeth ever hurt when you bite hard?	☐ Yes	☐ No

Name of your physician: _____

Address: _____

Phone: _____

Are you pregnant? ☐ Yes. If yes, what is the due date? _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken: ☐ Less than a year ago ☐ Longer than a year

Consent for Treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics', sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. 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. I authorise Lifetime Dental to use the details I've provided to correspond with me. I authorise that this data may be reviewed by team members of the dental practice.

Patient signature: _____ Date: _____

Parent/ Responsible party's signature: _____Date: _____

Please Note: Cancellation notice is <u>required 48 hours prior to appointment</u>. Failure to notify the practice will incur a fee.