SOUTHSIDE
Dental Implants
BRISBANE

14/259 McCullough St
Sunnybank QLD 4109

07 3345 2788

NEW PATIENT MEDICAL / DENTAL HISTORY FORM

Please note that all information on this form will remain strictly confidential. Please fill out clearly.

Contact Information

Mr / Mrs / Miss / Ms / Other: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Preferred Name: _____

Address: _____ Phone (Home): _____

_____ Phone (Mobile): _____

State: _____ Postcode: _____ Email Address: _____

Are you a member of a private health fund? If yes please state _____

Other Contacts

Emergency Contact Name: _____ Emergency Contact Phone: _____

Complete this only if the patient is under 18 years of age

Guardian Name: _____ Guardian Phone: _____

Guardian Address: _____

Medical History

Name of Your GP: _____ Your Doctor's Phone: _____

Your Doctor's Address: _____

Have you ever had any of the following?

- ☐ Anaemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Diabetes
- ☐ Bone disorders e.g. osteoporosis
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ HIV/ AIDS
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Respiratory problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumours
- ☐ Psychological Disorders

Are you pregnant, and if so how many months? _____

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Have you had any serious illnesses in the last 2 years?
If yes,please provide more information. _____

Are you currently taking any medications or tablets regularly?
If yes, please provide the name of the medication. _____

Do you take any tablets or injections that affect your bones? _____

Do you have any allergies to Penicillin or other drugs?
If yes, please provide the name of the medications you are allergic to. _____

Do you suffer from sleep apnoea? _____

Is your blood pressure normal, high or low? _____

Do you smoke? If so how many per day? _____

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (please tick as many as it applies)

- ☐ Sensitivity to hot or cold
- ☐ Staining of your teeth
- ☐ Food trapping between your teeth
- ☐ Clicking/pain in the jaw joints
- ☐ Discoloured fillings
- ☐ Roughness of existing fillings
- ☐ Bleeding gums
- ☐ Bad breath
- ☐ Sensitivity when eating
- ☐ Head/neck ache
- ☐ Grinding or clenching of your teeth

Are you concerned with: (please tick as many as it applies)

- ☐ Ability to eat
- ☐ your smile
- ☐ Silver fillings
- ☐ Gaps between your teeth
- ☐ Discolouration of your teeth
- ☐ Previous dental treatment
- ☐ Existing crowns, bridges or dentures
- ☐ Crooked teeth
- ☐ Tooth cleaning techniques (e.g. brushing & flossing)
- ☐ Missing teeth

What is the main purpose of your visit today? _____

How long since your last dental visit? _____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had or require the following for dental treatment?

☐ Gas (Nitrous oxide-laughing gas) ☐ Intravenous sedation ☐ General anaesthesia

Do you grant permission for your case to be used for continuing dental education/lecturing? ☐ Yes ☐ No

How did you hear about us?

☐ Google ☐ Facebook ☐ Yellow pages ☐ Referred by doctor / dentist ☐ Friend or Family ☐ Website
☐ Other_____

SIgned: _____ Full Name: _____ Date: _____