Todays Dental
creating beautiful smiles

Health history form

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

Surname: (Mr/ Mrs/ Miss/ Ms/ Dr.....	First name: .....
Date of birth:	Address: .....
Postcode:	Home phone: .....
Work phone:	Mobile: .....
Email:	Occupation: .....
Name of person responsible for fees,	Address: .....
if not self:	

Recommended by: .....

Purpose of visit: .....

Dental insurance company: .....

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

Have you had any of the following?

Heart problems	☐ Yes	Allergies to anaesthetics	☐ Yes
Blood pressure	☐ Yes	Allergies to penicillin	☐ Yes
Artificial joints	☐ Yes	Allergies to medications	☐ Yes
Rheumatic fever	☐ Yes	Allergies to latex	☐ Yes
Circulatory problems	☐ Yes	Anemia or other blood disorders	☐ Yes
Radiation treatment	☐ Yes	Diabetes	☐ Yes
Excessive bleeding	☐ Yes	Asthma	☐ Yes
Excessive bruising	☐ Yes	HepatitisABCDE	☐ Yes
Ulcers (stomach)	☐ Yes	Epilepsy	☐ Yes
Sinus trouble	☐ Yes	Liver or kidney problems	☐ Yes
Tumor history	☐ Yes		

Are you currently taking any medications? Yes ☐ No

If'yes',pleaselist: .....

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Have you had any of the following?

Does your jaw click or hurt? ☐ Yes

Do you feel you grind your teeth? ☐ Yes

Have you ever had orthodontic treatment? ☐ Yes

Do you wear a night guard? ☐ Yes

Have you ever had gum disease? ☐ Yes

Have you ever had your bite adjusted? ☐ Yes

Do you smoke? ☐ Yes

Do you think you have occasional bad breath? ☐ Yes

Do your gums ever bleed when you brush your teeth? ☐ Yes

Do you experience sensitivity with hot/cold? ☐ Yes

Does floss ever tear between your teeth? ☐ Yes

Does food get jammed between your teeth? ☐ Yes

Do your teeth ever hurt when you bite hard? ☐ Yes

Do you bite your lips or cheek often? ☐ Yes

Other notes .....

.....

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 that this data may be reviewed by team members of the dental practice.

Patient signature: ..... Date: .....

Parent/ responsible party's signature:.....

Relationship to patient: .....