Radiance DENTISTRY

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HEALTH HISTORY/NEW PATIENT FORM

Information about your medical history is essential for providing safe and effective dental treatment. Please take the time to complete this form as accurately as possible. Where you are unsure please discuss with your dentist.

Title:	First Name:	Family Name:
Preferrred Name:	DOB:	Occupation:
Postal Address:		
Contact Ph:	Email Address:	
Health Fund.	Account details:	

Emergency contact/ Next of kin:

Title:	First Name:	Family Name:
Contact Ph:	Relationship:	

General medical practitioner:

Dr:	Contact Ph:

Are you currently under the care of a medical specialist? ☐ Yes ☐ No

If yes, please complete the details below:

Name:	Type of specialty:	Ph or location:
Name:	Type of specialty:	Ph or location:

How did you find out about us?

Have you ever been diagnosed with or received treatment for any of the following:

		yes	no
Heart condition	e.g. angina, heart attack, by-pass operation, open heart surgery, arrhythmia, pacemaker, heart valve surgery, heart murmur	☐	☐
Blood pressure	e.g. high or low	☐	☐
Lung condition	e.g. bronchitis, asthma, emphysema, pulmonary embolism, neumonia	☐	☐
Liver disease	e.g. hepatitis, jaundice	☐	☐
Kidney disease	e.g. kidney failure, dialysis, infection, kidney stones	☐	☐
Bone disease	e.g. osteoporosis, Paget's disease, arthritis, hip/knee/joint replacement	☐	☐
Gastrointestinal, Stomach or digestive condition	e.g. stomach or peptic ulcer, reflux, Crohn's disease, Colitis	☐	☐
Stroke		☐	☐
Nervous or psychiatric condition	e.g. anxiety, depression, schizophrenia, ADHD	☐	☐
Epilepsy or seizures		☐	☐
Blood disorders	e.g. anaemia, leukaemia, excessive bleeding, Von Willebrand's disease, Haemophilia, low platelet count	☐	☐
Blood-borne viruses	e.g. HIV, viral Hepatitis	☐	☐
Immune conditions (steroid therapy)		☐	☐
Cancer (chemotherapy, radiotherapy)		☐	☐
Thyroid		☐	☐
Diabetes		☐	☐
Tuberculosis		☐	☐
Rheumatic fever		☐	☐
Eye condition	e.g. Cataracts, glaucoma	☐	☐
Skin condition		☐	☐
High cholesterol		☐	☐
Any other condition?		☐	☐

Have you been hospitalised in the last 12 months?	
Are you currently being treated by a doctor?	
Are you pregnant?	
When was your last dental visit?	
Purpose of visit?	

Have you had any operations or surgery?

Operation:	Year (date if remember):	Location surgery performed:

Do you have any disabilities?	
How does your disability affect your day to day activities?	

Medication History

	yes	no	Don't know
Do you currently take any prescription medicines in the form of pills or tablets?	☐	☐	☐
Do you currently take any non-prescription (over the counter) medicines (purchased in a pharmacy, supermarket, health shop, a naturopath or online)?	☐	☐	☐
Do you currently take any medication (prescription or non-prescription) in the form of eye/ear drops, inhalers/ puffers, or creams/ ointments?	☐	☐	☐
Have you ever received a medicine in the form of an injection or implant?	☐	☐	☐
Have you ever received medicinal treatment in the past for:	☐	☐	☐
Cancer	☐	☐	☐
Osteoporosis	☐	☐	☐
Paget's Disease	☐	☐	☐
Have you recently (in the last 2 months) taken and stopped any medication (e.g. an antibiotic, pain killer, or any other medication)?	☐	☐	☐
Have you recently (in the last 2 months) taken medication for the temporary relief of symptoms such as medicine for pain, reflux, sleep, dry eyes, dry mouth, constipation or any other?	☐	☐	☐
Have you ever taken any other person's medication?	☐	☐	☐
Have you recently (in the last 2 months) taken any other medication, pills or tablets of any kind, including "recreational" (e.g. alcohol, caffeine, marijuana, tobacco, weight loss meds) not included above?	☐	☐	☐
Have you ever taken any "recreational" medication or drugs?	☐	☐	☐

Please complete the details below:

Current Prescription Medication

Drug name:	Preparation/route e.g. oral, inhaler, injection, implant, mucosal, dermalogocal:	Dose:	Frequency:	Duration of use:	Purpose:

Current Non-Prescription and Recreational/Lifestyle Medication

Drug name:	Preparation/route:	Dose:	Frequency:	Duration of use:	Purpose:

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostics 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 the use of anesthetic 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. I understand and agree to pay the non-refundable cancellation payment of $75.00 if I cancel my appointment within the 24 hour period as per the cancellation policy.

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:	