Coffs Harbour	Woolgoolga	Toormina
176 Pacific Highway	43 Beach street	1/6 Minorca Place
Tel: 02 66523242	Tel: 02 66540650	Tel: 02 66531788

MEDICAL HISTORY FORM

In order to provide you with the highest standard of dental care, Magic Smiles needs to collect some personal information and details from you. Please complete this accurately so that we may be able to provide the best and safest care to you. Your answers are for our records only and will be kept confidential.

YOUR DETAILS

TITLE Mr / Mrs / Ms / Miss / Master / Doctor DOB _____

NAME _____ SURNAME _____

ADDRESS_____ SUBURB _____

STATE _____ POSTCODE _____

MOBILE PH _____ HOME PH _____

EMAIL _____ OCCUPATION _____

CONTACT PREFERENCE FOR APPOINTMENTS (CIRCLE) SMS PHONE

EMERGENCY CONTACT PERSON (Name/Number). _____

PRIVATE DENTAL INSURANCE: NAME _____ NUMBER: _____

DENTAL HISTORY

When was your last dental appointment? _____

Do you feel nervous about dental treatment? _____

Reason for today's visit?_____

Do you think you might grind or clench your teeth at night? _____

Do you suffer from sleep apnea?_____

MEDICAL HISTORY

1. Do you normally require antibiotic cover before treatment? No Yes
2. Have you had any abnormal reaction to local or general anaesthesia? No Yes
3. Are you being treated by doctor at present? No Yes
4. Women, are you pregnant? If so, how many months: No Yes

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5. Have you been hospitalised in the last 12 months? No Yes

6. Are you taking any medications at present? If so please list below. No Yes

_____

7. Please list any known allergies (including drugs, latex, food & preservatives.) _____

8. Have you ever had any of the following? Please tick yes or no for each condition.

	No	Yes		No	Yes		No	Yes
Steroid therapy			Excessive bleeding			Prosthetic implants		
Rheumatic fever			Stroke			eg artificial hip/knee		
Epilepsy			Cancer			Lung conditions		
Asthma			Tuberculosis			Hepatitis		
Diabetes			Thyroid disease			Liver diseases		
Bone disease, including osteoporosis			Nervous or psychiatric condition			Blood-borne viruses eg HIV		
Heart disorder			High/low blood pressure			Anaemia, leukaemia or		
Radiation therapy			Cardiac pacemaker			other blood diseases		
Kidney disease			Stomach disorders			Do you smoke?		

Any other condition(s) not mentioned please list:_____

How did you find out about us?
Internet Search_____ Advertising: Print/Radio/TV _____Referred by: _____
Other: _____

Dental photographs will often be taken to assist in the provision of your treatment. Our dentist area also involved in research and teaching. Do you consent for your photos to be shared with out of course your personal information (cross if you decline)
—With other dentists and oral Health professionals (Print/Email closed forums)
—In education of other patients
—On Public Social Media - Facebook/Instagram

Signed: Patient/Parent/Guardian:_____ **Date:**_____