Coffs Harbour
176 Pacific Highway
Tel: 02 66523242

Woolgoolga
43 Beach street
Tel: 02 66540650

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 **DATE OF BIRTH:** _____

FIRST NAME: _____ **STREET ADRESS:** _____

LAST NAME: _____ **SUBURB:** _____

STATE: _____ **POSTCODE:** _____

MOBILE PH: _____ **HOME PHONE:** _____

EMAIL: _____ **OCCUPATION:** _____

EMERGENCY CONTACT PERSON:

NAME:_____**PHONE:**_____

PRIVATE DENTAL INSURANCE NAME/ OR MEDICARE(Under 18yro):_____

MEMBER NUMBER ON CARD:_____ **POSITION AS LISTED ON CARD (eg. 01) #**_____

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. **Are you being treated by doctor at present?** **No** **Yes**
3. **Women, are you pregnant? If so, how many months:** **No** **Yes**
4. **Have you been hospitalised in the last 12 months?** **No** **Yes**
5. **Please list any known allergies (including drugs, latex, food & preservatives.)**

_____

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6. Are you taking any medications currently? If YES please list below, or provide reception with a medication list

_____

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

	No	Yes		No	Yes		No	Yes
Arthritis			Cancer Type_____			Prosthetic implants eg artificial hip/knee		
Asthma			Steroid Therapy					
Diabetes Type 1 2			Radiation Therapy			Liver Disease		
Epilepsy			Anemia			Rheumatic Fever		
Excessive bleeding			Blood Disease or Virus _____			Thyroid Disease		
Bone disease, including osteoporosis			HIGH or LOW blood pressure (please circle one)			Nervous or psychiatric condition (e.g. anxiety, depression)		
Heart disorder Type- _____			Hepatitis: A B C			Lung Conditions Or Emphysema		
Stroke/Heart Attack			Kidney Disease			Tuberculosis		
Pacemaker			Stomach disorder/s			Do you smoke?		

Other condition(s) not mentioned, please list: _____

How did you find out about us?

Internet Search:_____ **Advertising: Print/Radio/TV** _____

Referred by: _____ **Building Signage/walking past:** _____

Other:_____

<u>Dental Photographs</u> will often be taken to assist in the provision of your treatment. Our dentist area also involves research and teaching. Do you consent for your photos to be shared with the following?
(Please note that no personal information/details will be shared)

—With other dentists and oral health professionals (Print/Email closed forums) **No** **Yes**

—For the education of other patient's **No** **Yes**

—On website or public social media - Facebook/Instagram **No** **Yes**

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