New Patient
Medical and Dental History

smileline
DENTAL CARE

Dr Nasser Elhage | Dr Sarah Kara- Ali | Dr Mohamed Hosny
Dr Maha Mahmassani | Miss Salli Adil Ali

Patient details

Title : ☐ Mr ☐ Master ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Surname: Given Name: D.O.B:

Residential Address:

Suburb: State: Postcode:

Postal Address (If Different):

Home Phone: Work Phone: Mobile:

Email :

☐ We will send you email communications from time to time, including appointment reminders and our regular newsletter. Please tick if you don't wish to receive communication from us

Occupation: Company:

Emergency Contact Name: Phone: Relation:

Private Health Insurer: Member #: Patient #:

Medicare #: Ref#: Expiry: Vets Afairs: Expiry:

GP Name: GP Phone:

GP Address:

Preferred Method of Communication

☐ Email ☐ SMS ☐ Letter ☐ Telephone

Medical History

Do you have any of the following medical conditions? ☐ **No** **Yes (Please tick below)**

☐ Abnormal/ Excessive Bleeding
☐ Angina
☐ Artificial Heart Value
☐ Asthma
☐ Blood Disorder (name below)
☐ Blood Thinner
☐ Bone Disease (e.g. Osteoporosis)
☐ Current or past bisphosphonate therapy
☐ Cancer
☐ Cardiac Surgery/ Pacemaker
☐ Congenital Heart Defect
☐ Diabetes Type 1 / Type 2
☐ Epilepsy
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A / B / C / D
☐ HIV Positive
☐ Immune Deficiency
☐ MS
☐ Nervous Disorder
☐ Oral Ulverations
☐ Prosthetic Joints
☐ Psychiatric Care
☐ Radiation/ Chemotherapy
☐ Reflux
☐ Rheumatic Fever
☐ Steroid Therapy
☐ Stroke
☐ Other Conditions (name below)

Medical History (continued)

Are you pregnant? ☐ No ☐ Yes If so, due date?

Are you Aboriginal or Torres Strait Islander? ☐ No ☐ Yes

Do you have any allergies? ☐ No Yes (Please tick below)

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha Drugs
☐ Other (please specify)

Are you a smoker? ☐ No ☐ Yes If so, how many cigarettes a day?

Are you taking any medication (including natural supplements)? ☐ No ☐ Yes (Please specify below)

Dental History

Last Dental Visit: Is there any particular reason for your visit today:

Have you ever had a reaction or complication following dental treatment in the past? ☐ No ☐ Yes (please specify below)

Is here anything else the dentist or hygienist should be aware of?

Do you generally feel anxious about seeing your dentist and/or hygienist?
☐ Yes- Extremely ☐ Yes- Very ☐ Yes-Somewhat ☐ No- Not at all

Are you suffering from any of the following? ☐ No ☐ Yes (Please tick below)

☐ Bad appearance of teeth	☐ Discoloured teeth	☐ Loose teeth	☐ Sensitive teeth
☐ Bad breath	☐ Dry mouth	☐ Lost filling/cavity	☐ Sounds from joint
☐ Bleeding gums	☐ Grinding/Clenching	☐ Rapidly decaying teeth	☐ Toothache
☐ Difficulty chewing	☐ Missing teeth	☐ Pain in jaw/face	☐ Unsatisfactory Denture

Have you ever had a sleep study and been diagnosed with sleep apnoea?	☐ Yes	☐ No
If ye, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy?	☐ Yes	☐ No
Has anyone ever told you that you snore?	☐ Yes	☐ No
After 6-7 hours of sleep do you wake up refreshed?	☐ Yes	☐ No

How did you find out about us?

☐ Google ☐ Website ☐ TV advert ☐ Billboard advert ☐ Bupa
☐ Other (please specify) ☐ Referred by friend/family

Privacy Policy and Signature

Any information is collected and maintained in accordance with State and Federal Privacy Legislation. A copy of our privacy policy can be obtained online from our website. I have accurately completed this medical history form to the best of my knowledge.

I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment us due at the time of service unless other arrangements have been made.

I authorise my dentist to take images of my teeth both before and after my treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.

Patient Name: Signature: Date:

OFFICE USE ONLY
Form check by:_____ Data keyed by _____ Keying checked by_____ From scanned by _____