BAYFIELD DENTAL

NEW PATIENT MEDICAL & DENTAL HISTORY FORM

Welcome to Bayfield Dental. We provide high quality dental care. To assist us in treating you, please complete this form. The information you provide will remain strictly confidential.

Title: _____ First name (s): _____ Surname: _____

Address: _____

_____ Postcode: _____

Date of birth: _____/____ /_____ Occupation: _____ Employer: _____

Phone: (H) _____ (W) _____ (M) _____

Name of doctor: _____ Address of doctor: _____

Emergency contact name: _____ Emergency contact number: _____

Who referred you to our practice? _____

Health fund: _____

Do you have or have you ever had any of the following medical conditions? (please circle Yes [Y] or No [N]):

Heart disease	Y	N	Hepatitis A B C	Y	N	Depression and/or anxiety	Y	N
Angina	Y	N	HIV/AIDS	Y	N	Mental illness	Y	N
Heart defect	Y	N	Asthma	Y	N	Gastro-oesophageal reflux	Y	N
Rheumatic fever	Y	N	Tuberculosis	Y	N	Arthritis	Y	N
Artificial heart valve	Y	N	Kidney disease	Y	N	Osteoporosis	Y	N
High or low blood pressure	Y	N	Diabetes	Y	N	Artificial joint	Y	N
Pacemaker	Y	N	Epilepsy	Y	N	Cancer	Y	N

Do you have or have you had any other illness or been in hospital in the last five years? If yes, please specify:

_____

_____

List ALL medications that you take, prescription and non-prescription:	Reason for taking medications:

Do you have any allergies (e.g. medications, foods, metals, latex)? Please list: _____

_____

Do you smoke or have you ever been a smoker? Y N

WOMEN: Are you pregnant? Y N Are you breastfeeding? Y N

Do you have any concerns about your teeth? If so please specify: _____

_____

Do you wear a mouth guard when playing contact sport? Y N Have you ever suffered any dental trauma? Y N

What is the main purpose of your visit today? _____

_____

How long since your last dental visit? _____

PLEASE INFORM US OF ANY CHANGES TO YOUR MEDICAL HISTORY OR MEDICATIONS AS THIS CAN RELATE TO YOUR DENTAL TREATMENT

As part of my treatment I understand that my personal details and/or x-rays may be sent to a specialist.
I understand that the practice requires at least 24 hours notice of cancellation of scheduled appointments, and that a cancellation fee may be charged if I fail to do so.

Patient's Signature: _____ Date: _____ / _____ / _____