DENTAL IMPLANTS ILLAWARRA

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3/66 Central Ave,
Oak Flats, NSW, 2529
dentalimplantsillawarra.com.au

1. Your Details

Full Name: _____
Title First Name Surname
Preferred Name: _____Date of Birth: _____
Postal Address: _____ Suburb_____ Postcode _____
Telephone: Mobile _____ Home _____ Work _____
E-mail Address: _____
Do you belong to a Private Health Insurance Fund? _____ if yes, which one? _____
How did you hear about us? _____

2. Additional Contact Details

In case of emergency, who should be contacted?
Name: _____ Contact Details: _____
Relationship to patient: _____

3. Medical Health History

Have you been under the care of a medical doctor during the last 2 years? Yes / No
If yes, for what? _____

Please list all medical doctors that you have been under the care of in the last 5 years:

Doctor/Specialist	Contact details	Condition Treated	Date of Treatment
…….	…….	…….	…….
…….	…….	…….	…….
…….	…….	…….	…….

Are you taking any prescribed or over the counter medication, natural remedies or supplements? Yes / No
If yes, please list name and dosage: _____ _____
_____ _____
_____ _____

Do you smoke? Yes / No If Yes, how many per day? _____

Are you aware of having an allergic or adverse reaction to any medication or substance? Yes / No
If yes, please list: _____

Have you ever taken or been given medication for Osteopenia or Osteoporosis? Yes / No
If yes, please list: _____

Do you take any recreational drugs? Yes / No
If yes, please list: _____

Please indicate which you have had previously or have at present. Please circle 'Yes' or 'No' to each

Heart or Vascular Disease or Surgery	Yes / No	Asthma or Bronchitis	Yes / No
Chest Pain or Heart Attack	Yes / No	Lung or Respiratory Disorder	Yes / No
Congenital Heart Problem or Murmur	Yes / No	Cold sores / Blisters	Yes / No
High Blood Pressure	Yes / No	Sinus Trouble or Hay Fever	Yes / No
Low Blood Pressure	Yes / No	Neurological Disorders	Yes / No
Mitral Valve Prolapse / Artificial Valve	Yes / No	Epilepsy / Seizures	Yes / No
Cardiac Pacemaker	Yes / No	Fainting, Blackouts or Dizziness	Yes / No
Rheumatic Fever	Yes / No	Anxiety/Panic Attacks	Yes / No
Stroke / TIA	Yes / No	Depression	Yes / No
Blood Disease / Bleeding Disorder	Yes / No	Stomach Ulcers	Yes / No
Anaemia	Yes / No	Digestive Problems	Yes / No
Hepatitis A, B, C or carrier	Yes / No	Diet Restriction	Yes / No
HIV / AIDS	Yes / No	Eating Disorder	Yes / No
Liver Disease or Cirrhosis	Yes / No	Prosthetic Joints (hips/knee etc.)	Yes / No
Kidney Trouble	Yes / No	Organ/Bone Marrow Transplant	Yes / No
Thyroid Disorder	Yes / No	Radiotherapy	Yes / No
Diabetes Type I or II	Yes / No	Chemotherapy	Yes / No
Arthritis or Rheumatism	Yes / No	Cancers or Tumors	Yes / No
Steroid or Cortisone Treatment	Yes / No	General Anesthetics/Operations	Yes / No
Swollen Ankles, Hands or Feet	Yes / No	Infectious Diseases	Yes / No
Reflux or Heartburn	Yes / No	Genetic related disorder	Yes / No

Do you have or have you previously experienced any disease or condition not listed above? Yes/No
If yes, please list: _____

Ladies - Are you, could you be Pregnant? Yes – Weeks _____ / No
- Nursing? Yes / No
- Family Planning / Undergoing Fertility Treatment? Yes / No
- Taking Birth Control? Yes / No

4. Dental Health History

Do you require antibiotics prior to dental treatment? Yes / No

Does food or floss constantly get stuck between your teeth? Yes / No
Do your gums bleed when brushing? Yes / No
How often do you brush your teeth: _____
How often do you floss your teeth? _____

Do you experience or have you experienced any of the following:

☐ Frequent Headaches / Migraines	☐ Neck Pain
☐ Jaw Joint Pain or Stiffness	☐ Facial Pain
☐ Jaw Joint Noise, Clicking or Popping	☐ Postural problems / Back Pain
☐ Limited opening/closing of your mouth	☐ Tonsil / Adenoid Removal
☐ Pain behind the eyes	☐ Numbness
☐ Ear Ache, Stuffiness or Congestion	☐ Tingling Hands or Feet
☐ Ringing in the ears / Tinnitus	☐ Muscle Spasm, Cramping or Soreness
☐ Clenching / Grinding of your teeth	☐ Chronic Sore Throat
☐ Difficulty Swallowing	☐ Chronic Fatigue
☐ Trauma to the Jaw, Face, Head or Neck	☐ Daytime tiredness or Lethargy

Please advise your dentist as to the frequency and time of day that these problems occur.

We have surveillance cameras throughout our clinic. If you do not agree to be filmed on CCTV (Security Camera) for security purposes, we are unable to treat you. By signing below, you give consent to being filmed on CCTV, and confirm that all information given in this form is true, complete and accurate.

Signature: _____ Date: _____