MINCHINBURY
Dental Care

This practice aims at the very best in modern dental treatment, with the smallest amount of discomfort possible. To help achieve our goals please fill in this medical/dental history form. All information provided remains confidential.

Mr/Mrs/Ms/Miss/Mst SURNAME: _____ FIRST NAME: _____

Date Of Birth: _____ ADDRESS: _____

SUBURB_____ P/CODE: _____ HOME PHONE: _____

MOBILE PHONE: _____ WORK PHONE: _____

Where did you hear about Minchinbury Dental Care: Yellow Pages Directory / Yellow Pages Online / Newspaper
(please circle the appropriate answer) Internet / Your Health fund / You live locally / Doctor

If it was a friend or family member please specify who so we can thank them: _____

DENTAL HISTORY

What are your dental concerns? _____

Do you have any objections to us taking x-rays? Yes/No

(Note: if we do not take x-rays we may not be able to fully diagnose your dental conditions or we may miss potential problems) Dr. D.Mercieca would prefer you see one of the other dentists in the practice if you do not want x-rays taken. Dr. James Lee and Dr John Hills will treat you for a recall appointment or general check up if you do not want x-rays taken.

Please **tick** which of the following options for treatment are you interested in? (You may leave this section blank if you are unsure or if it does not apply to you)

- IV Sedation (Pain Free): Drowsy pain Free State, ideal for extractions, multiple fillings and patients scared of dental procedures. Please note that you are not asleep during this procedure, only drowsy, relaxed and pain free.
- General Anaesthetic: Performed at Minchinbury Community Hospital. This option will ensure that you are completely 'knocked out' or asleep during treatment.
- Nitrous (Happy gas): Ideal for scale & cleans and small fillings without needles.
- Just needles in the mouth
- No needles for dental work

Are you covered by a health fund for dental treatment? YES/NO Which fund? _____

Are you interested in having an interest free payment plan (conditions apply)? YES/NO

We have the HICAPS claim system for your convenience.
Please have your health fund card ready at the end of your appointment.

Payment method

Please be aware that we do not give accounts. All treatment MUST be paid at the time of your appointment. We accept payment by cash, credit card, EFTpos and cheque. We can also provide an **INTEREST FREE** payment plan (conditions apply). Ask our staff for more information. Any price quoted over the phone is a minimal starting price. An accurate quote will be given after consultation with the dentist.

Signed: _____ Date: _____

MINCHINBURY DENTAL CARE

PATIENT MEDICAL ASSESSMENT FORM

SURNAME_____ **GIVEN NAME**_____

DATE OF BIRTH_____

Do you have OR have you ever had:	**Yes**	**No**	**Please state which applies**
Physical disability			
An allergic reaction to Drugs/Antibiotics/food/latex			
Heart trouble/chest pain			
Heart surgery/valve repair or replacement			
Have you had Joint replacement or implant surgery			
Do you have a cardiac pacemaker			
Heartburn/Reflux			
Blood pressure problems			
Rheumatic fever			
Stroke			
Anaemia or other blood disorders eg clots			
Diabetes			
Lung disease Asthma/bronchitis			
Do you snore or suffer sleep apnoea			
Liver disease or jaundice eg Hepatitis A, B, C or HIV/AIDS			
Kidney disease			
Muscle disease or weakness			
Back, neck or hip problems or arthritis			
Do you suffer from epilepsy			
Thyroid problems			
Have you been diagnosed with cancer, if so are you or have you received either chemotherapy &/or radiotherapy			
Have you taken steroids/cortisone in the last 6 months			
Problems with anaesthetics-general or local			
Has any member of your family had problems with anaesthetics			
Do you smoke (indicate number per day)			
Do you drink (indicate number per day)			
Have you ever used any recreational substances			
Have you ever been an IV drug user			
Are you taking any herbal medications			
Do you have any problems with your jaw			
Are you needle phobic			
Do you suffer anxiety attacks or fainting spells			
Do you suffer from osteoporosis			
Have you ever taken medication for osteoporosis			
FEMALE PATIENTS ONLY			
Could you be pregnant			
Are you breast feeding			
Have you had a mastectomy if so which side			
Have you had reconstructive surgery after your mastectomy			

Please list current medications

Drug	Dosage	Frequency

Is there a History of taking any of the following: (please circle)

Aspirin Yes / No

Sleeping Tablets Yes / No

Warfarin Yes / No

Nerve Tablets Yes / No

Drugs to stop Clotting Yes / No

List of operations and approximate dates:

_____

_____

_____

_____

_____

NAME OF YOUR GP_____ Contact number _____

Patient /Guardian Signature_____**Date**_____

OFFICE USE ONLY

I Dr.Mercieca, Dr Lee, Dr.Hills, Dr Wan (please circle) have read and discussed with the patient their medical history, and have made appropriate documentation in the patients treatment notes.

Signed_____Date_____

ASA SCORE: