Manchester Rd Dental Services Trust
ABN 807 307 49 557

Manchester Rd
DENTAL SURGERY

Dr. David Rivadillo
BDSc Hons (Melb) Provider 4345724B
Dr. Amanda Ho
BDSc (Melb) Provider 4226999Y
& Associates

Dear valued client,

Welcome to our practice. Please take your time to answer the following questions as carefully and thoroughly as possible. It will greatly assist us in providing you optimal care. All information will be treated with complete professional confidentiality. Thank you for your assistance.

CONTACT DETAILS

Title : Mr / Mrs / Ms / Miss / Master / Dr Surname: .....

Given names: .....

Date of birth: ..... Home phone: ..... Mobile: .....

Home address: ..... Suburb: ..... P/Code: .....

Email: .....

Postal address (if different to above): .....

Person responsible for fees: .....

Emergency contact: ..... Relationship: .....

Address: ..... P/Code: ..... Ph: .....

Medical doctor and practice name: ..... Ph: .....

Who recommended this practice to you? .....

DENTAL HISTORY

Do you have dental insurance? Yes/No Which fund? .....

Are you concerned about any of the following regarding your teeth?

☐ Currently causing pain ☐ Wear ☐ Shape ☐ Position ☐ Colour

⇨ ⇨ ⇨ **PLEASE TURN OVER TO COMPLETE MEDICAL INFORMATION** ⇨ ⇨ ⇨

MEDICAL HISTORY

Have you ever had any of the following? Please indicate by TICKING YES or NO:

	YES	NO		YES	NO
High blood pressure	☐	☐	Diabetes	☐	☐
Heart problems	☐	☐	Thyroid problems	☐	☐
Rheumatic fever	☐	☐	Excessive bleeding or blood disorder	☐	☐
Asthma, chest, or breathing problems	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
Gastric reflux	☐	☐	AIDS/HIV	☐	☐
Kidney disease	☐	☐	Bone disorders incl. osteoporosis	☐	☐
Radiation therapy for cancer	☐	☐	Anxiety/psychology/mental health	☐	☐

If you have a heart problem, please circle if it is: angina / a pacemaker / a stent / heart valve problem previous infective endocarditis / other: .....

Do you have an artificial heart valve, hip, or other prosthetic implant? .....

Do you smoke? **YES** ☐ **NO** ☐ If yes, how many each day? .....

Female patients, is there the possibility you may be pregnant? If so, how many weeks? .....

Any other medical history your dentist should be made aware of? .....

MEDICATIONS

There are many medications that may impact your oral health or treatment we plan for you. Please indicate by TICKING and LISTING, any medications that you are currently taking or have taken recently.

☐ Cancer medication ..... ☐ Corticosteroids .....

☐ Heart or blood pressure medication ..... ☐ Diabetes medication .....

☐ Blood thinners *e.g. Warfarin, Plavix, Aspirin, Coumadin* .....

☐ Bisphosphonates *e.g. Didronel, Bonefos, Fosamax, Alendro, Actonel, Skelid, Aredia, Pamisol, Zometa* .....

Other medications, please list: .....

Have you previously had any Botox, anti-wrinkle injections or dermal fillers? YES ☐ NO ☐

ALLERGIES & ADVERSE REACTIONS

Do you have any allergies? If yes, please state allergy and its affect on you .....

I have completed the questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I give permission for the practice to use the above contact details to send me appointment and recall reminders.

☐ I give permission for the practice to use anonymous photos of my teeth for marketing purposes

Patient/guardian/carer signature ..... **Date** .....