WELCOME TO DR EDWARDS FAMILY DENTAL

PERSONAL DETAILS

Mrs Date of Birth DD/MM/YYYY

Surname Given Name Preferred Name

Postal Address Postcode

Residential Postcode

Phone (Hm) (Mob) (Wk)

Email

Name of Health Fund Member Number

Medicare Number Reference

Veterans' Affair Card Number

Occupation/place of employment

CONTACT IN CASES OF EMERGENCY

Name of Contact Relationship

Phone (Hm) (Mob) (Wk)

GENERAL MEDICAL – PRIVATE AND CONFIDENTAL

Who is your general practitioner? Phone

Are you receiving medical treatment now? ☐ Yes ☐ No

Have you stayed in hospital or had an operation in the last 10 years? ☐ Yes ☐ No

If yes, please give details

Have you had a sleep test in the last 12months? ☐ No ☐ Yes study done with

To the best of your knowledge, do you have or have you ever had:

Heart complaint/treatment	☐ Yes	☐ No	Gastric Ulcer	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Radiation Therapy/Chemotherapy	☐ Yes	☐ No
Blood Disorders	☐ Yes	☐ No	Treatment for any form of cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Transplanted Organ or Bone Marrow	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Pregnant (Due Date)	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Cognitive Impairment	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Sleeping Issues	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Obstructive Sleep Apnoea	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Snoring	☐ Yes	☐ No
Tuberculous	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Daytime Tiredness	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Do you smoke ☐ Social	☐ Yes	☐ No
Joint Replacement Surgery	☐ Yes	☐ No	Have you previously smoked?	☐ Yes	☐ No
Osteoporosis/Low Bone Density	☐ Yes	☐ No			

Do you have any other medical problems? ☐ Yes ☐ No

If yes, please specify

Current Medications (prescription, over the counter or herbal)?

Allergies ☐ Nil Known ☐ Yes, please specify

DENTAL HISTORY

Toothache recently	☐ Yes ☐ No	Bleeding or Tender Gums	☐ Yes ☐ No
Clenching or Grinding of teeth	☐ Yes ☐ No	Mouth Ulcers	☐ Yes ☐ No
Sensitive Teeth (hot/cold)	☐ Yes ☐ No	Bad Breath or Bad Taste in mouth	☐ Yes ☐ No
Headaches or Migraines	☐ Yes ☐ No	Other (please give details)	
Jaw Joints clicking or hurting	☐ Yes ☐ No		

Would you like more information about?

Teeth whitening ☐ Yes ☐ No Replacing missing teeth ☐ Yes ☐ No Oral Appliances ☐ Yes ☐ No

Have you had any complications from dental treatment in the past? ☐ Yes ☐ No

Have you had any complications from local anaesthetic in the past? ☐ Yes ☐ No

Would you like a regular examination reminder? ☐ Yes ☐ No

Are you happy for a reminder the day before your next appointment? ☐ No ☐ SMS ☐ Phone

THE EPWORTH SLEEPINESS SCALE how likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing

Sitting and reading	**0-3**	
Watching television or screens	**0-3**	
Sitting inactive in public place (e.g. a theatre or meeting)	**0-3**	
As a passenger in a car for an hour without a break	**0-3**	
Lying down to rest in the afternoon when circumstance permit	**0-3**	
Sitting and talking to someone	**0-3**	
Sitting quietly after lunch without alcohol	**0-3**	
In a car, while stopped for a few minutes in the traffic	**0-3**	
	Total/24	**/24**

1-6 Congratulations, you are getting enough sleep!

7-8 Your score is average

9 and up Very sleepy and should seek medical advice

It is important that your dentist has your current medical history and understands your health needs before any examination or treatment is carried out. Medical information will be kept strictly confidential, in accordance with the Privacy Act 1988.

I agree that the above is a true and accurate record. Payment on the day is required. Any expenses, costs or disbursements incurred by Dr Edwards Family Dental in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may result in a failure to attend fee.

PLEASE NOTE: The medical information gathered will be electronically copied to your clinical record file and the original copy will be subsequently destroyed. By signing this document, you agree to this process. This form is a guide only you should discuss any relevant matters with your dentist prior to the commencement of any dental treatment.

Patient's Signature _____ Date _____

Dentist's Signature _____ Date _____

OFFICE USE		
Entered By	Scanned in	Date