PRODENTAL CLINIC
BAULKHAM HILLS

MEDICAL HISTORY AND NEW PATIENT FORM

Shop 94-95 Stockland Mall, 375 Windsor Rd. Baulkham Hills NSW 2153 Tel: (02) 9639 9555 / Fax: (02) 9639 9655

Welcome to Prodental Clinic. We would like to get to know you better. Please fill in as much as you can. If you have any questons or unsure, feel free to ask any one of us.

YOUR BASIC DETAILS

Mr Mrs Ms Miss Surname :	**First name :**	**Preferred name :**
D.O.B : (dd/mm/yy) / /	**Referred by :**	
Private health Insurance name :	**Occupation :**	

CONTACT DETAILS

Address :	
Phone number :	**Mobile:**
Email :	
Emergency contact :	
GP details :	
Main reason for your visit today :	

YOUR MEDICAL CONDITION (PLEASE TICK)

I'm medically healthy with no medications and no known allergies OR I have the following medical conditions :

☐ Heart problems, blood pressure, bypass or valvular replacement, rheumatic fever
☐ Liver problems, hepatitis ☐ Psychiatric consultation, depression, anxiety disorder, bipolar, memory loss
☐ Epilepsy, convulsions or seizures ☐ Thyroid problems ☐ Herpes or cold sores, AIDS or HIV
☐ Dry mouth, dry eyes ☐ Neuropathic pain disorder ☐ Diabetes, arthritis
☐ Stomach problems, reflux, ulcers ☐ Bleeding tendency or excessive bruising
☐ Broken bones of the face, neck, jaw or back, back trouble
☐ Breathing/Lung problems, asthma, tuberculosis, sinusitis, flu
☐ Recent surgery (within 12months, please specify): _____

Please list any medications you are currently taking :

Are you allergic to any medications or anesthetics? ☐	**Are you pregnant/breastfeeding? ☐**	**Do you smoke? ☐**

DENTAL HISTORY (PLEASE TICK)

Have you experienced any dizziness, fainting, excessive bleeding or other major concerns from the previous treatments? ☐		
Do you want to improve the look of your teeth / smile? ☐	**When was your last dental visit? ☐**	
Do you suffer from headaches in the early morning? ☐	**Do you grind your teeth at night? ☐**	**Does your jaw click? ☐**
Do you suffer from sensitivity? ☐	**Do you notice bleeding gums? ☐**	**Do you get bad breath? ☐**

I confirm that the above is true and will take responsibility of any outcomes that arise from misleading information.

Patient's signature : _____ **date (dd/mm/yy) :** _____

Witness name / signature : _____ **date (dd/mm/yy) :** _____

The above information is strictly confidential. Thank you for your time!