EXCEPTIONAL DENTAL

Shop 3,
9-11 Elkhorn Ave
Surfers Paradise 4217
Phone: 07 5504 7002
Email:info@exceptionaldental.com.au

MEDICAL HISTORY

In order to provide you with the exceptional dental care, Exceptional Dental needs to collect personal information and details from you. Please complete this accurately so that we may be able to provide the best and safest care to you. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you may be asked additional questions relating to your responses where it will help our clinicians better your care.

YOUR DETAILS

TITLE Mr / Mrs / Ms / Miss / Master / Dr / Other DOB ______________

FIRST NAME ______________ SURNAME ______________

PREFERRED NAME ______________

ADDRESS ______________

SUBURB ______________ POSTCODE ______________

MOBILE PH ______________ HOME PH ______________

EMAIL ______________ OCCUPATION ______________

EMERGENCY CONTACT PERSON (NAME/NUMBER) ______________

DO YOU HAVE DENTAL INSURANCE? Y ▪ N NAME OF FUND? ______________

DENTAL HISTORY

DO YOU FEEL NERVOUS ABOUT DENTAL TREATMENT? Y (1 ▪ 2 ▪ 3 ▪ 4 ▪ 5) N

WHEN WAS YOUR LAST DENTAL APPOINTMENT?

REASON FOR TODAY'S VISIT?

HOW DID YOU HEAR ABOUT US? (Please Tick)

- ☐ Walked past the practice
- ☐ Facebook
- ☐ Google
- ☐ Health Fund
- ☐ Instagram
- ☐ Recommended by someone If so, who? ______________

If so, who?

MEDICAL DOCTORS NAME ______________ PRACTICE NAME & PHONE/ E-MAIL ______________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS/ INJECTIONS? Y ▪ N

Please list: ______________

ARE YOU CURRENTLY UNDERGOING ANY MEDICAL TREATMENT? Y ▪ N

Please list: ______________

HAVE YOU HAD ANY MAJOR SURGERIES/ ILLNESS/ DISEASES IN THE PAST? Y ▪ N

Please list: ______________

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DO YOU HAVE ANY ALLERGIES? (E.G. LATEX, ANAESTHETIC, MEDICATIONS/DRUGS,FOODS Etc.) Y ▪ N

Please list:

DO YOU SMOKE OR VAPE? Y ▪ N # PER DAY ________

ARE YOU PREGNANT OR BREAT FEEDING? Y ▪ N

HAVE YOU HAD BOTOX BEFORE? Y ▪ N

HAVE YOU HAD ANY OF THE FOLLOWINGS? (Please tick)

☐ High blood pressure
☐ Low blood pressure
☐ Rheumatic fever/ Rheumatic heart disease
☐ Heart Valve/ Pacemaker
☐ Other heart conditions
☐ Stroke
☐ Hepatitis
☐ HIV/ AIDS
☐ Blood/ Bleeding disorders
☐ Asthma
☐ Sinus issues
☐ Other respiratory conditions

☐ Prolia injections
☐ Sleep apnea
☐ Diabetes
☐ Stomach ulcers/ Indigestion/ Acid reflux
☐ Fainting/ Epilepsy/ Seizures
☐ Cancer
☐ Radiation/ Chemotherapy
☐ Artificial joints
☐ Osteoporosis/ Other bone disorders
☐ Depression
☐ Anxiety
☐ ADD/ ADHD

List any other conditions/ diseases: ________________________________

Our dentists are also involved in research and teaching. Do you consent for your photos to be shared?

☐ With other dentists and oral health professionals(print/email/online closed forums)

☐ In the education of other patients

☐ On public social media- Facebook/Instagram

I have completed the above to the best of my knowledge and all information collected will be treated in confidence. I understand that payment is to be made at the time of my appointment. I understand that if I need to reschedule my appointment, I will give Exceptional Dental 24 hours notice. If I fail to give 24 hours notice, a cancellation fee may apply.

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Patient or Guardian Name Patient or Guardian Signature Date