medlanddental
Technical excellence. Exceptional care.

NEW PATIENT MEDICAL HISTORY

These details provide us with information required for your optimal dental treatment and oral health care. Your Privacy & Confidentiality will be respected at all times. To view our privacy policy please ask for a printout. It may sometimes be necessary to consult with other health professionals. Please feel free to discuss any health questions in confidence with your Dentist.

First Name:	Surname:
Title:	Date of birth:
Home Phone:	Address:
Mobile Phone:	Postcode:
Email:	Preferred Contact:
Private Health Insurance:	Occupation:

Please indicate if you have **(or have previously had)** any of the following:

Heart problems
Blood pressure
Artifical joints
Rheumatic fever
Circulatory problems
Radiation treatment
Excessive bleeding/bruising
Mental illness
Sinus trouble
Cancer History
Anemia or other blood disorder
Do you smoke? /day
Are you pregnant?
Are you currently taking medication?
If yes, please list:

Diabetes
Asthma
Epilepsy
Hepatitis ABCDE
Liver or Kidney problems
Osteoporosis
Allergies to anaesthetics
Allergies to penicillin
Allergies to medications
Allergies to latex
Other

Name of your doctor: Phone no:
Next of kin/relationship: Phone no:

Your Privacy and Confidentiality

To achieve your optimal dental care it may be necessary to consult with other dental professionals. In some cases we are asked questions on the phone by parents, spouses or friends with regard to appointments or treatment; we need your consent to disclose any details. I give my permission to discuss my dental care when necessary with:

1. Other dental professionals: 2. Family members: 3. Non-family members:

Continued overleaf →

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NEW PATIENT DENTAL HISTORY

Does you jaw click or hurt?	Yes	No
Do you grind your teeth?	Yes	No
Have you had orthodontic treatment?	Yes	No
Do you wear a night guard/splint?	Yes	No
Do you experience sleep apnoea?	Yes	No
Have you ever had gum disease?	Yes	No
Do you think you have occasional bad breath?	Yes	No
Do your gums ever bleed when you brush?	Yes	No
Do you experience sensitivity to hot or cold?	Yes	No
Does floss ever tear between your teeth?	Yes	No
Do your teeth ever hurt when you bite hard?	Yes	No

How long since your last dental appointment?

How often do you have dental examinations?

Previous dental x-rays were taken how long ago? (approx)

As we like to thank current patients or other healthcare providers for their kind referrals, if you were referred please provide the name of the person who referred you:

How did you hear about our practice?

Yellow Pages	Flyer	Returning patient
Event	Google	
Advertisment	Facebook	
Signage	Other	

Medland Dental strives to reduce our carbon footprint by sending digital communications wherever possible. This includes payment invoices, receipts and statements, appointment reminders, patient referral and loyalty vouchers, event invitations, practice newsletters, offers and information. Please be assured your details are kept securely and not distributed to third parties.
Do you agree to receive electronic communication from Medland Dental? Yes No

Consent for Treatment

I hereby authorise Medland Dental Centre to take x-rays, study models, photographs & other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me & to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives & other medication as necessary. I fully understand I can ask for a full recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf & on behalf of my dependents. I understand that payment is due at the time of service.

Patient Signature: Date:

Relationship to patient:

Dentist Signature: