DENTAL HEALTH CARE ASSOCIATES

MEDICAL AND DENTAL
EVALUATION FORM

Welcome to our Dental Practice.
Please complete this form
to assist us in evaluating your treatment needs

Private & Confidential

Kurrajong House, 4th Floor, 175 Collins Street, Melbourne 3000
Ph: (03) 9650 2909 Fax: (03) 9650 3137

Surname:_____ **Date of Birth:**_____
(MR/MRS/MISS/MS/DR)
First Name:_____ **Private Phone:**_____

Address:_____ **Business Phone:**_____

_____ **Mobile:**_____

_____ **P/Code:**_____ **E-mail:** _____

Occupation:_____**Employer**:_____

Person Responsible for Fees: _____

Address*: (if different from above)* _____

_____**Postcode:**_____

Next of Kin: _____**Telephone:** _____

Recommended By: *(please tick)*

❑Friend/family/college ❑Other

Name: _____

MEDICAL DETAILS
Do you have or have you had any of the following? *(please tick)*

	YES	NO		YES	NO
Any heart problems	❑	❑	Allergies to : Anaesthetic	❑	❑
Blood Pressure	❑	❑	Penicillin	❑	❑
Heart Murmur	❑	❑	Medications/Drugs _____	❑	❑
HIV	❑	❑	Other _____	❑	❑
Rheumatic Fever	❑	❑	Anaemia or blood disorders	❑	❑
Circulatory Problems	❑	❑	Diabetes	❑	❑
Nervous Problems	❑	❑	Asthma	❑	❑

Radiation Treatment	❑	❑	Hepatitis – A B C D E F G	❑	❑
Excessive Bleeding	❑	❑	Epilepsy	❑	❑
Excessive Bruising	❑	❑	Liver or Kidney Problems	❑	❑
Stomach Ulcers	❑	❑	Tumor History	❑	❑
Sinus Trouble	❑	❑	*Ladies,* are you pregnant?	❑	❑
Artificial Joints/prosthesis	❑	❑	If yes, due date?_____		

Are you currently taking any medications? ❑ ❑
Please name them: _____

Have you ever been hospitalised? ❑ ❑
If so, when and what for?_____

The Name of your Medical Doctor?_____Location _____

If applicable

The Name of your Specialist? _____ Location_____

	YES NO *(please tick)*
Have you aver had trouble with previous dental experiences?	❑❑
Does your jaw "click" or "hurt"?	❑❑
Do you feel you grind your teeth?	❑❑
Have your teeth worn down and become discoloured?	❑❑
Do you wear a night guard?	❑❑
Have you had orthodontic treatment (Braces)?	❑❑
Do you like the colour of your teeth?	❑❑
Do you like the arrangement of your teeth?	❑❑
Do you like the shape of your teeth?	❑❑
Do you have spaces between your teeth?	❑❑
Does their appearance bother you?	❑❑

	YES NO
Do your gums bleed when you clean your teeth?	❑❑
Do you feel you suffer from bad breath?	❑❑
Have you had previous gum problems?	❑❑

Previous Dentist Name: _____

Previous Xrays:
❑ **Less than 1 year** ❑ **Longer than 1 year**

In a few words, please explain the purpose for today's visit:_____

_____

Thank you, for taking the time to complete this form, the information you have provided will assist us to offer you comprehensive dental care.

SIGNED _____ DATE: / / .