CLARINDACLINIC
Complete Dental Care

NEW PATIENT MEDICAL & DENTAL HISTORY FORM

General Information:

SURNAME: Mr/Ms/Mrs/Miss		GIVEN NAMES:	
D.O.B:		OCCUPATION:	
PHONE (H): PHONE (W): Phone (M):		POSTAL ADDRESS: EMAIL:	
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE:	

Details only if the patient is under 18 years old.

PARENT/ GUARDIAN NAME		PHONE NUMBER:	

Referral information: **Where did you find out about us? Please tick:**

☐ Internet/ website ☐ Walked past ☐ Live locally ☐ Yellow pages

☐ Other medical practitioner___ _

☐ Patient (please provide name so that we can thank them)_____

Medical information: **Have you ever had any of the following? Please tick:**

☐ ANAEMIA	☐ GLAUCOMA	☐ RESPIRATORY PROBLEMS
☐ ARTIFICIAL JOINTS	☐ HEART DISEASE	☐ RHEUMATIC FEVER
☐ ASTHMA	☐ HEART MURMOUR	☐ SINUS PROBLEMS
☐ BLOOD DISEASES	☐ HEPATITIS A, B, C	☐ STROKE
☐ CANCER/ TUMOURS	☐ HIV / AIDS	☐ TUBERCULOSIS
☐ DIZZINESS	☐ HIGH BLOOD PRESSURE	☐ PSYCHOLOGICAL DISORDERS
☐ EPILEPSY	☐ KIDNEY DISEASE	☐ PREGNANT
☐ EXCESSIVE BLEEDING	☐ LIVER DISEASE	☐ BREAST FEEDING
☐ DIABETES	☐ PACEMAKER	☐ ARTHRITIS
☐ FAINTING	☐ RADIATION THERAPY	☐ OSTEOPOROSIS

Medical information continued:

Have you had any serious illnesses in the last 2 years? If yes please explain.	
Are you currently taking any drugs, medications, inhalers or tablets regularly? If yes, please list.	
Are you taking or have you taken bisphosphonate (osteoporosis) drugs?	
Do you have any allergies to drugs, medicines, latex or other? Describe the adverse reaction.	
Do you snore or suffer from sleep apnoea?	
Are you being treated for any other condition not listed?	
Do you / have you ever smoked? If yes, how many per day?	

Dental Information: Are you concerned about or experiencing any of the following dental problems?

☐ Sensitivity/ pain to hot or cold	☐ Staining of teeth	☐ Bleeding gums
☐ Food trapping between teeth	☐ Sensitivity/ Pain when eating	☐ Bad breath
☐ Discoloured fillings	☐ Grinding or clenching teeth	☐ Bad taste
☐ Clicking or pain in jaw joints	☐ Roughness of existing fillings	☐ Head/ neck ache

Are you concerned with?

☐ Existing crowns, bridges or dentures	☐ Ability to eat	☐ Gaps between teeth
☐ Problems brushing/ flossing	☐ Your smile	☐ Discoloured teeth
☐ Crooked teeth	☐ Missing teeth	☐ Silver fillings
☐ Previous dental treatment		

What is the main purpose of your visit today?

How long since your last dental visit, and why? _____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Consent for services:

- I hereby give consent for a dental examination and understand that the information I have provided is accurate and will be kept confidential for dental purposes only.
- I understand that payment is required on the day of treatment.
- I understand that a minimum of 24 hours' notice is required if I need to cancel my appointment and late cancellation fees may apply

Patient signature: _____ **Date:** _____