



FirstBite PATIENT HISTORY FORM

Mr Miss Ms Mrs Mst

D.O.B:

Surname:	Address:
First Name:	Postcode:
Home Phone:	Mobile:
E-mail:	Drivers Licence No:
Business Name:	Occupation:
Business Address:	Business Phone:
Emergency Contact:	Phone:

MEDICAL HISTORY

Doctor's Name:	Phone:
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Have you had any of the following?

Rheumatic Fever
 Tuberculosis
 Excessive bleeding
 Epilepsy
 Diabetes
 High Blood Pressure
 Aids/HIV
 Hepatitis A, B, C
 Asthma
 Kidney Disease
 Heart Ailment

Other Medical Problems:

Are you currently under medical care or taking any medication? Y N **If yes, what?**

Are you currently taking osteoporosis medication? Y N

Are you allergic to any drugs, medicines or latex? Y N **If yes, what?**

Have you been hospitalised in the last 5 years? Y N **If yes, what for?**

Do you have an artificial hip, heart valve or other prosthetic implants? Y N **If yes, what?**

Are you a smoker? Y N **WOMEN.** Are you pregnant? Y N

DENTAL HISTORY

Have you ever had any problems with dental treatment? Y N **If yes, describe:**

Have you had your wisdom teeth removed? Y N

Does dental treatment make you nervous? Y N

Are you aware of clenching or grinding your teeth, day or night? Y N

Please indicate the last time you visited the dentist:

Are you here for: Check Up
 Toothache
 Appearance
 Clean
 Other Reasons

Chief complaint about your teeth:

Is there anything about your smile you would like to change? Y N **If yes, what?**

Do you have dental insurance? Y N **If yes, which fund?**

HOW DID YOU EVER KNOW WE EXISTED? (Tick as many as appropriate)

Recommended by someone
 Seen the practice
 Brochure
 Flyer or Postcard in mail
 Advertising
 Yellow Pages Ad
 Newsletter
 Email newsletter
 First Bite Website
 Google
 Yahoo
 yellowpages.com.au
 dentist.com.au (Your Dentist)
 mylocal.com.au
 truelocal.com.au
 Sponsorship

I have completed the above to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk. I also understand that I am fully responsible for the financial aspect of my dental treatment.

Checked: Date: Signed:

Guardian's Name: