Align Dentistry & Medical Centre
A Dental, Orthodontic & Medical Surgery
3/54 Governor Macquarie Drive, Chipping Norton NSW 2170

Child Dental Medical history form

Patient Information

Date _______________

Patient's Name____

Address ____ Sex: M / F

Mobile # ______________________________ Home Phone # ____________________________

Birthdate _______ /_____/_________ Ethnicity / Background ______________________________

Patient's school: ____________________________________

How did you hear about our practice? ***(Please circle)***

Google Referred Live locally Word of mouth Flyers/Advertising Family/Friends Facebook

Parent / Guardian Information/ Emergency Contact

Parent / Guardian name: _________________________ Relationship to child: ________________________

Mobile: ______________ Tel: _____________________ Email address: _________________________________

Insurance Information

Name of Health Insurance ______________________ Series ________ (Number next to your name on card)

Medicare card number ____________________________Reference number _______
(Patient eligible for child dental benefit schedule (Medicare)

Medical History

Name of Doctor: ____________________________ Phone: ____

Address: ____

Has your child been under the care of your doctor during the past 2 years? Yes / No

If yes, what for: ____

Are you aware of your child having any allergic (or adverse) reaction to any medication? Yes / No

If yes, Please specify: ____

Has your child been a patient in hospital during the past 5 years? Yes / No

If yes, what for: ____

Is your child taking any medication or drugs? Yes / No
If Yes, Please Specify: ____

Are you sensitive or allergic to any medication or anaesthetics? Yes / No
If Yes, Please specify: ____

Medical Information

Indicate which of the following you have had or have at the present. Circle "yes or no"

Heart (surgery, disease attack)	**Yes / No**	**Stroke**	**Yes / No**
Chest Pain	**Yes / No**	**Stomach Ulcers**	**Yes / No**
Congenital Heart Disease	**Yes / No**	**Diabetes**	**Yes / No**
Heart Murmur	**Yes / No**	**Thyroid Problem**	**Yes / No**
High Blood Pressure	**Yes / No**	**Glaucoma**	**Yes / No**
Mitral Valve Prolapse	**Yes / No**	**Emphysema**	**Yes / No**
Artificial Heart Valve	**Yes / No**	**Chronic Cough**	**Yes / No**
Heart Pacemaker	**Yes / No**	**Tuberculosis**	**Yes / No**
Rheumatic Fever	**Yes / No**	**Asthma**	**Yes / No**
Arthritis / Rheumatism	**Yes / No**	**Hay Fever**	**Yes / No**
Cortisone Medicine	**Yes / No**	**Latex Sensitivity**	**Yes / No**
Swollen Ankles	**Yes / No**	**Allergies or Hives**	**Yes / No**
Diet (Special/Restricted)	**Yes / No**	**Sinus Troubles**	**Yes / No**
Radiation Therapy	**Yes / No**	**Chemotherapy**	**Yes / No**
Cold Sores / Fever Blisters	**Yes / No**	**Haemophilia**	**Yes / No**
Bruise Easily	**Yes / No**	**Liver Disease**	**Yes / No**
Kidney Trouble	**Yes / No**	**Epilepsy or Seizures**	**Yes / No**
Neurological Disorders	**Yes / No**	**Nervous / Anxious**	**Yes / No**
Fainting or Dizzy Spells	**Yes / No**	**Tumours**	**Yes / No**

◯ **None of the above**

Do you have or have you had any disease, condition, or problem not listed? Yes / No

If yes, please specify: ____

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient / Parent signature ______________________________ Date____________________

FOR OFFICE USE: Reviewed by Dr. ______________________________ Date: ____________________

We are pleased you have selected us to provide dental care for you and your family.

Book your next dental appointment faster in the HealthEngine app

(General dental patients only)

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Adult Dental Medical history form

Patient Information Date: _______________

Patient's Name________________________________

Address ____________________________________ Sex: M / F

Mobile # ____________________ Home Phone # ____________________

Birthdate ______ /_____/________ Ethnicity / Background ________________________

How did you hear about our practice? ***(Please circle)***

Google Referred Live locally Word of mouth Flyers/Advertising Family/Friends Facebook

Emergency Contact ____________________ Ph. # (___) ____________________

Insurance Information

Name of Health Insurance ____

Card/Membership Number________________________ Series__________
(Number next to your name on card)

Medical History

Name of Doctor: ____________________________ Ph.________________

Address: ____

Have you been under the care of your doctor during the past 2 years? Yes / No

If yes, what for: ____

Are you aware of any allergic (or adverse) reaction to any medication? Yes / No

If yes, Please specify: ____

Have you been a patient in hospital during the past 5 years? Yes / No

If yes, what for: ____

Are you taking any medication or drugs? Yes / No
If Yes, Please Specify: ____

Are you sensitive or allergic to any medication or anaesthetics? Yes / No

If Yes, Please specify: ____

Dental History

When was your last visit to a dentist? _______________ Do you suffer from sensitivity? Yes / No

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What is the purpose of your visit today? ____

Medical Information

Indicate which of the following you have had or have at the present. Circle "yes or no"

Condition		Condition	
Heart (surgery, disease attack)	**Yes / No**	**Stroke**	**Yes / No**
Chest Pain	**Yes / No**	**Stomach Ulcers**	**Yes / No**
Congenital Heart Disease	**Yes / No**	**Diabetes**	**Yes / No**
Heart Murmur	**Yes / No**	**Thyroid Problem**	**Yes / No**
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Neurological Disorders	**Yes / No**	**Nervous / Anxious**	**Yes / No**
Fainting or Dizzy Spells	**Yes / No**	**Tumours**	**Yes / No**

◯ **None of the above**

Do you have or have you had any disease, condition, or problem not listed? Yes / No

If yes, please specify: ____

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Patient signature ____ Date________________

FOR OFFICE USE: Reviewed by Dr__________________________ Date_________________

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