Align Dentistry

3/54 Governor Macquarie Drive, Chipping Norton NSW 2170

Child Dental Medical history form

Card No._____

Patient Information

Date _____ Patient's Name_____

Address_____

Home Ph.# (___) _____ Sex: M / F

Mob# _____ Birthdate _____/_____/_____

Emergency Contact (name)_____ Ph. # (___) _____

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

Parent / Guardian name: _____ Relation to child:_____

Address:_____

Mobile:_____ Tel: _____

Email address: _____

Insurance Information

Name of Health Insurance_____

Card/Membership Number_____ Series_____

(Number next to your name on card)

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: _____

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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

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.

Parent /Guardian Signature _____ Date_____

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

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

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Adult Dental Medical history form

Card no:_____

Patient Information

Date _____ Patient's Name_____

Address_____

Home Ph.# (___) _____ Mob. # _____

Work Ph.#_(___)_____ Sex: M / F Birthdate _____/_____/_____

Email: _____

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

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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

What is the purpose of your visit today? _____

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