Welcome to Coffs Coast Dental

Coffs Coast Dental
where beautiful smiles are made

Health History form

So that we can provide the highest standard of care and look after your needs, please fill in this form carefully and thoroughly:

☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR

Surname: ..... First Name: ..... Preferred Name: .....

Address: ..... Post Code: .....

Home Phone: ..... Mobile Number: .....

Email: ..... Date of Birth: .....

Occupation: ..... Work Phone: ..... Company health fund: .....

Emergency contact: ..... Emergency Phone: .....

Preferred method of contact: ☐ Phone ☐ SMS ☐ E-Mail ☐ Letter/Mail

Dental insurance company: ..... Recommended by: .....

Purpose of visit: .....

Is another member of your family a patient at our office: ☐ YES ☐ NO How do you feel about seeing a dentist? .....

How long has it been since your last dental visit? ..... How often do you have dental examinations? .....

How did you hear about us? ☐ Word of Mouth ☐ Practitioner referral ☐ Website ☐ Letter box/postcard Other:

Notice to insured patients regarding dental benefits insurance

Item numbers on our statement represent as accurately as possible the procedures performed but in no way are they a claim on anyone other than the patient for whom they were performed. The egilibility of the patient, or the procedures, to attract refunds, and the rates of those refunds, are determined by the conditions of the patient's Health Insurance Policy. We accept no responsibility, to either party, for any decision the insurer may make regarding the refund of monies to the patient.

Medical History

Primary Care Physician Name: ..... Physician Phone Number: .....

Address: ..... Post Code: .....

Have you had any of the following?

Heart problems	☐ YES	☐ NO	Ulcers (stomach)	☐ YES	☐ NO	Anemia or other blood disorders	☐ YES	☐ NO
High/Low Blood pressure	☐ YES	☐ NO	Sinus trouble	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Artificial joints	☐ YES	☐ NO	Tumor History	☐ YES	☐ NO	Asthma	☐ YES	☐ NO
Rheumatic fever	☐ YES	☐ NO	Allergies to anaesthetics	☐ YES	☐ NO	Hepatitis A, B, C, D or E	☐ YES	☐ NO
Circulatory problems	☐ YES	☐ NO	Allergies to penicillin	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO
Radiation treatment	☐ YES	☐ NO	Allergies to medications	☐ YES	☐ NO	Liver or kidney problems	☐ YES	☐ NO
Excessive bleeding	☐ YES	☐ NO	Allergies to latex	☐ YES	☐ NO	HIV/AIDS	☐ YES	☐ NO
Excessive bruising	☐ YES	☐ NO						

Any other condition: .....

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Do you have allergies? ☐ YES ☐ NO

If yes please list any medicines or products you are allergic to (e.g. Penicillin, Latex):

.....

Are you pregnant: ☐ YES ☐ NO

If yes, what is your due date?

.....

Are you taking any medications? ☐ YES ☐ NO

If yes please list: .....

.....

.....

Are you being treated by your Doctor at present? ☐ YES ☐ NO

If yes, what for? .....

.....

.....

Have you had any of the following?

Does your jaw click or hurt?	☐ YES	☐ NO	Do you smoke?	☐ YES	☐ NO
Do you feel you grind your teeth?	☐ YES	☐ NO	Do you think you have occasional bad breath?	☐ YES	☐ NO
Have you ever had orthodontic treatment?	☐ YES	☐ NO	Do your gums ever bleed when you brush your teeth?	☐ YES	☐ NO
Do your wear a night guard?	☐ YES	☐ NO	Do you experience sensitivity with hot/cold?	☐ YES	☐ NO
Have you ever had gum disease?	☐ YES	☐ NO	Does floss ever tear between your teeth?	☐ YES	☐ NO
Have you ever had your bite adjusted?	☐ YES	☐ NO	Does food get jammed between your teeth?	☐ YES	☐ NO
Do you bite your lips or cheek often?	☐ YES	☐ NO	Do your teeth ever hurt when you bite hard?	☐ YES	☐ NO

Other notes: .....

.....

Previous dental x-rays were taken: ☐ Less than a year ago ☐ Longer than a year ago

Name of Person who is responsible for Payment: .....

We ask that full Payment be made at each Appointment. Payment can be made by EFTPOS, Cash and Cheques are also accepted.

Please mark the payment method you will be using: ☐ Cash ☐ Cheque ☐ Eftpos ☐ Credit Card

Privacy policy

Should you require copies of any or all of the contents of your dental file, requests must be made in writing and written consent given if records are transferred to another practice. A fee is applicable. Please ask our staff for the current fee.

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics', sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I authorise that this data may be reviewed by team members of the dental practice.

☐ **Please tick, as confirmation that you have read and understood the privacy policy and consent to the use of your health information in this way.**

☐ **Please tick to confirm that you have read and understood our payment policy.**

Patient signature: ..... Date: .....

Parent / responsible party's signature: ..... Relationship to patient: .....

Please ensure to advise any changes to the above on future visits.