SAPPHIRE DENTISTRY

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New Patient & Medical History Form

Title: Mr / Mrs / Miss / Ms / Dr / Other: _____

First Name: _____

Surname: _____

Date of Birth: _____

Occupation: _____

Phone (Home): _____

Phone (Mobile): _____

Phone (Work): _____

Address: _____

_____

Email: _____

_____

Emergency Contact: _____

Relationship: _____

Ph: _____

Medical Doctor: _____

Clinic: _____

Ph: _____

Health Fund: _____

How did you find us?

- ☐ Google
- ☐ External Signage
- ☐ Facebook
- ☐ Instagram
- ☐ Family/Friend: _____
- ☐ Other: _____

Have you ever had or are you currently suffering from any of the following? Please tick if yes.

- ☐ Diabetes: (Type 1 / 2)
- ☐ Heart Disorder/Complaint
- ☐ High Blood Pressure
- ☐ Excessive Bleeding
- ☐ Steroid Therapy
- ☐ Cancer
- ☐ Chemo/Radiation Therapy
- ☐ HIV / Hepatitis A, B or C?
- ☐ Sleep Apnea
- ☐ Asthma / Lung disease
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Epilepsy
- ☐ Psychiatric Condition
- ☐ Anxiety / Depression
- ☐ Blood Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Prosthetic Implant (hip / heart / joint)
- ☐ Bone Disease – Osteoporosis/Paget's?
- ☐ Cardiac Pacemaker
- ☐ Thyroid Disease
- ☐ Stomach/Digestive Condition
- ☐ Rheumatic Fever
- ☐ Pregnant - Weeks: _____

Further details:_____

_____

Are you a Smoker? For how long and how many per day: _____

Do you have any allergies (eg. Penicillin, Latex): _____

If you take medications, please list in the table below. If you have a longer list, please inform our staff.

Medication	Dose	Last taken	Medication	Dose	Date taken
1.			3.		
2.			4.		

Please tick as many of the following problems you have been experiencing.

- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Chew
- ☐ Difficulty Eating
- ☐ Worn/Broken Teeth
- ☐ Discoloured Teeth
- ☐ Loose Teeth
- ☐ Denture Problems
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Food Trapping
- ☐ Head/Neck Ache
- ☐ Sore/Clicking Jaw
- ☐ Grinding/Clenching
- ☐ Snoring
- ☐ Waking up at Night

In signing this form, I acknowledge that this document represents an accurate medical history. I will advise my dentist of any changes in the future and understand this information will be treated with professional confidentiality. I agree to be responsible for all payments of fees and understand payment is due at the time of service. If you default in making payment and recovery/legal action is undertaken, you will be responsible for all expenses in relation to collection of the outstanding amount, including but not limited to all charges, fees, legal costs on an indemnity basis and discernments

Patient/Guardian Signature: _____ **Date:** _____/_____/_____