RIVERWALK DENTAL

New Patient Medical History Form

Mr Mrs Miss Master Ms Dr

First Name: Surname: Preferred Name:

Date of Birth: Email:

Address:

Mobile: Home Phone: Occupation:

Private Health Insurance: Name of GP/Practice:

Emergency Contact Name and Number:

How did you discover our surgery/who do we thank?

Dental Information

What is the purpose of your visit today?	
Do you generally feel anxious about seeing your dentist/hygienist?	☐ Yes ☐ No ☐ Sometimes
Do you use an electric or manual toothbrush?	
How often do you brush your teeth?	
Do your gums bleed when your brush your teeth?	☐ Yes ☐ No ☐ Sometimes
Do you regularly clean between your teeth? Example	Floss Waterpik Piksters
Are you happy with the appearance of your teeth and smile? If no, what about your teeth do you not like:	☐ Yes ☐ No ☐ Colour ☐ Shape ☐ Size ☐ Position of Teeth

Medical Information

Do you regularly take prescription or non-prescription drugs or medication? If so, please list below:

Have you ever taken or are you currently taking the following medications: Alendronate, Fosamax, Risedronate, Pamidronate, Zoledronic Acid? Please circle/list:	
Do you require antibiotic cover prior to dental treatment?	☐ Yes ☐ No
Have you ever had a serious problem associated with any previous dental treatment? If yes, please explain:	☐ Yes ☐ No
Have you ever had a bad reaction to medication or treatment?	☐ Yes ☐ No
Do you smoke/vape/use other forms of tobacco?	☐ Yes ☐ No
Do your gums bleed when your brush your teeth?	☐ Yes ☐ No ☐ Sometimes
Have you previously smoked? If yes, how long ago?	☐ Yes ☐ No
For women: Are you pregnant? If so, how many weeks?	☐ Yes ☐ No

Please TICK if you have, or have ever had any of the following

☐ Allergies/Hypersensitivities list:_____	☐ Corticosteroid Therapy	☐ Leukaemia
☐ Anaemia	☐ Crohn's Disease or Colitis	☐ Liver or Kidney Disorder
☐ Anxiety/Depression	☐ Diabetes: Type I or II **(CIRCLE)**	☐ Nerve/Muscle Disorder
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Gastro-Intestinal Disorder	☐ Prosthetic Joint: Hip or Knee
☐ Cancer	☐ Heart Murmur, Heart/Vascular Disorder	☐ Radiation of head/neck
☐ Cardiac Pacemaker	☐ Heart Attack	☐ Rheumatic Fever
☐ Chemotherapy	☐ High | Low Blood Pressure **(CIRCLE)**	☐ Stomach Disorder
	☐ Infectious/Blood Borne Disease	☐ Stroke
		☐ Vertigo

Signature of Patient, Parent/Guardian: _____ Date: _____