orangefamily DENTAL
147 Hill Street, ORANGE, NSW 2800
(02) 6362 1100
reception@orangefamilydental.com.au
orangefamilydental.com.au

Health History Form

Please review and complete the following questionnaire, so we can ensure we are looking after your needs.
Please advise if you require assistance to complete this form.

Title: (Mr/ Mrs/ Ms/ Miss/ Master/ Dr/ Other/ Mx.) Full Name:	Address: Suburb:
Date of birth:	Mobile:
Home phone:	Emergency Contact Name:
Occupation:	Emergency Contact No:
Email:	
Name of person responsible for fees, if not self:	
Do you have a Health Care Card (HCC) or Pensioner Concession Card (PCC)? ◯ Yes ◯ No	

Do you have Private Dental Cover? ◯ Yes ◯ No If so, Company Name: _____

Member Number: _____ Person Number: _____

Are you eligible for the Medicare Child Dental Benefit Scheme? ◯ Yes ◯ No

If so, Medicare Number: _____ Person Number: _____

Is another member of your family a patient at our office? ◯ Yes, please name: _____ ◯ No

Please tick any of the following that apply to you or if you wish to disclose any of the below. Multiple can be ticked if multiple apply:

I identify as ◯ Aboriginal ◯ Torres Strait Islander ◯ Neither ◯ Both

I am under 18 years of age ◯ Yes

I have a disability ◯ Yes

I am over the age of 65 ◯ Yes

I come from a culturally or linguistically diverse background ◯ Yes

I live in a rural or remote area ◯ Yes

I am from a non-English speaking background ◯ Yes

I am from a low socio-economic background ◯ Yes

I have difficulty with reading, writing, or understanding information ◯ Yes

I am medically compromised ◯ Yes

I have a decline or change in physical, mental, or cognitive health ◯ Yes

I am currently managing addiction or substance use issues ◯ Yes

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Have you had any of the following? If yes, please tick.

Heart problems/Heart Surgery	◯ Yes	Anaemia or other blood disorders	◯ Yes
Blood pressure	◯ Yes	Asthma	◯ Yes
Artificial joints	◯ Yes	Hepatitis A B C D E	◯ Yes
Rheumatic fever	◯ Yes	Epilepsy	◯ Yes
Circulatory problems	◯ Yes	Liver or kidney problems	◯ Yes
Radiation treatment	◯ Yes	Hospital visit in the last 12 months	◯ Yes
Excessive bleeding	◯ Yes	Allergies to latex	◯ Yes
Excessive bruising	◯ Yes	Allergies to anaesthetics	◯ Yes
Ulcers (stomach)	◯ Yes	Allergies to penicillin	◯ Yes
Sinus trouble	◯ Yes	Allergies to medications (please list) _____	
Tumour/Cancer history	◯ Yes	_____	

Other health conditions or allergies (please list - if listed not above)

_____

Are you currently taking any medications? ◯ Yes ◯ No

If "yes", please list: _____

Have you had any of the following?

Does your jaw click or hurt?	◯ Yes	Do you feel you have occasional bad breath?	◯ Yes
Do you feel you may grind your teeth?	◯ Yes	Do your gums bleed when you brush your teeth?	◯ Yes
Have you ever had braces/orthodontic treatment?	◯ Yes	Do you experience sensitivity to hot/cold?	◯ Yes
Have you ever had gum disease?	◯ Yes	Does food get caught between your teeth?	◯ Yes
Have you ever had your teeth whitened?	◯ Yes	Do you smoke?	◯ Yes
Have you used/do you use recreational drugs?	◯ Yes	Do you drink alcohol?	◯ Yes

Any other concerns? _____

_____

_____

Name of your GP: _____

Are you pregnant? ◯Yes ◯ No If yes, when is your due date? _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

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

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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. If you are unsure of the information provided by your dentist and/or the oral health therapist, please do not hesitate to ask for more information on costings or treatment discussed.

I authorise that this data may be reviewed by team members of the dental practice.

Patient signature: _____ Date: _____

Parent/responsible party's signature: _____

Relationship to patient: _____

Confirmations and Cancellations

For your convenience we routinely confirm your appointment with 1 week and 24 hours notice via SMS text message and/or by phone call. If you need to reschedule your appointment, we request that you please give us 48 hours notice. This allows us to fill the appointment especially for patients that require urgent care. If adequate notice is not given you may incur a cancellation fee.
I hereby understand the cancellation policy. **Patient Signature**: _____