# GOODISON (DENTAL) SERVICES – PATIENT HISTORY FORM

At Goodison Dental Services, we strive to provide you with the best possible care. To do this, we need to collect personal information about you and your general health, both past and present. Please provide as much detail as possible. All information is kept in accordance with State & Federal Privacy Legislation.

Title: ..... Surname: ..... First Name: ..... Date of Birth: .....

Home Address: .....

Ph: ..... Mobile: ..... (B/H) Ph: .....

Email: .....

Person responsible for Fees (including address): .....

Emergency Contact: ..... Relationship: .....Ph: .....

Medical Doctor (including address): ..... Ph: .....

**How did you find us?**

**Website .... Social Media .... Yellow Pages .... Chronicle .... Word of Mouth .... Personal Referral (name) .....**

## HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| High blood pressure | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Heart ailment/disease or family history | ☐ | ☐ | Thyroid problems | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | Excessive bleeding or blood disorder | ☐ | ☐ |
| Asthma, chest or breathing problems | ☐ | ☐ | Epilepsy | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Cancer | ☐ | ☐ | AIDS/HIV | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | Bone Disorders or Diseases | ☐ | ☐ |

List any other previous illness: .....

Do you have: an artificial hip, heart valve or other prosthetic implant? ..... ☐ ☐

Are you taking any drugs, medicines or tablets? (prescribed or other)..... ☐ ☐

Please list all: .....

Do you have any Allergies: (e.g. Penicillin, latex).....

Do you smoke? YES ☐ NO ☐ How many? ____/day. Would you like to stop smoking? YES ☐ NO ☐

How anxious are you about dental treatment on a scale of 1-10 ☐

Is there anything in your past that may affect your dental treatment ? .....

Female patients, are you pregnant?

**Do you Snore? YES ☐ NO ☐**

**Do you have any concerns with any of the following: (please circle if applicable)**

**Snoring / Sleep Apnoea / Interrupted Sleep / Tiredness / Difficulty Concentrating / Drowsiness when driving**

***I have accurately completed this pre-clinical questionnaire to the best of my knowledge.***
***I understand and consent to my notes, radiographs (x-rays), photo's or models being sent to other dental practitioners to aid them in my treatment if necessary.***
***I consent for non-identifiable photo's of my mouth (teeth only) to be used by the practice.***
***I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders via SMS, email or by post.***

Signed: .....Date: .....

**ON FUTURE VISITS, CHANGES TO ANY OF THE ABOVE SHOULD BE ADVISED**

**www.goodisondental.com.au**