Patient Medical & Dental Information

At LARA dental we strive to provide you with the highest possible Dental Care.
Filling in this form as accurately as possible will help us to achieve this.
Please be aware that we send appointment reminders via SMS.

Ph: 03 5282 3201
14 Forest Rd South, Lara VIC 3212
enquiries@laradental.com.au

Patient Details

Title: Surname: Given Name(s):

Preferred Name: Date of Birth:

Residential/Postal Address:

Suburb: Post Code:

Home Phone: Mobile:

Email Address: ☐ *Please tick this box if you don't wish to receive email communications like newsletters from Lara Dental*

Emergency Contact Name: Phone:

Person responsible for fees:

Private Health Fund Name:

Who is your medical practitioner? Phone:

How did you hear about us?

☐ Referred by family member, friend or colleague. Whom may we thank?

☐ Website ☐ Google ☐ Social Media ☐ Other. Please specify:

Medical Information

We appreciate your time and effort in answering the following questions fully. They are very important in ensuring that we diagnose any dental concerns in association with your overall medical health.
Many medical conditions influence dental health and conversely many chronic dental diseases impact on the function of major organs, general health and wellbeing.

Are you under the care of a Doctor at the moment for any serious medical condition? If yes, please specify:

Please indicate and detail if any of the following apply to you now or ever in the past

	NEVER	PAST	PRESENT
Are you a smoker?	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood Disorder/Excessive Bleeding	☐	☐	☐
Blood Pressure (High or Low)	☐	☐	☐
Cardiac Pacemaker	☐	☐	☐
Diabetes	☐	☐	☐
Contact with HIV/AIDS	☐	☐	☐
Epilepsy	☐	☐	☐
Gastric Reflux Problem	☐	☐	☐
Heart or Vascular Disorders	☐	☐	☐

	NEVER	PAST	PRESENT
Kidney Disorders	☐	☐	☐
Liver Disorder/Hepatitis	☐	☐	☐
Osteoporosis	☐	☐	☐
Prosthetic Implant	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Neuromuscular Disease	☐	☐	☐
Auto Immune Disease	☐	☐	☐

Females: Are you, or could you possibly be pregnant now? If yes, how many months?

Please list any over the counter or prescribed medications that you take:

Have you ever had an allergic reaction to any medications or procedures? ☐ Yes ☐ No If yes, please provide details:

Have you ever had any serious health issues? ☐ Yes ☐ No If yes, please provide details:

Have you ever had any of these specific class of medicines: *Bi-phosphonates, Neuromuscular Inhibitors, Dermal Fillers or Botox?*

☐ Yes ☐ No If yes, please specify:

Dental Information

When was your last Dental visit? What Treatment did you have?

Have you ever had any Orthodontic treatment? ☐ Yes ☐ No Do you use a dental splint? ☐ Yes ☐ No

Have you had any of the following?

	Yes	No		Yes	No
Toothache	☐	☐	Problems chewing your food	☐	☐
Sensitive Teeth (to hot/cold/pressure)	☐	☐	Problems opening or closing your jaw	☐	☐
Lost filling or Cavity	☐	☐	Clenching or Grinding your teeth	☐	☐
Decaying Teeth	☐	☐	Pain in your Face or Jaw	☐	☐
Worn or broken teeth with sharp edges	☐	☐	Clicking or Popping Jaw	☐	☐
Bleeding Gums	☐	☐	Snoring or Sleep Apnoea	☐	☐
Loose Teeth	☐	☐	Morning Headaches	☐	☐
Missing Teeth or Gaps	☐	☐	Dry Mouth	☐	☐
Discoloured Teeth or Fillings	☐	☐	Halitosis (bad breath)	☐	☐
Loose Denture	☐	☐	Any other dental issues (please specify)	☐	☐
Unsightly appearance	☐	☐			

What is the purpose of today's visit?

Privacy and Consent

- Please be assured any information is collected and maintained in accordance with State and Federal Privacy Legislation. If you would like any further information about how we use and protect your personal information, please ask our staff for "personal Information, Privacy and your Dentist" document.
- I have accurately completed this medical history form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made. We do not offer credit for treatment at LARA dental however we do recommend a number of agencies that may offer financial assistance. Please ask our friendly staff members.
- I authorise my dentist and dental staff at LARA dental to take images of my teeth and face for clinical, educational and promotional purposes, while keeping my identity anonymous to all persons except staff at LARA dental ☐ **YES** ☐ **NO**
- I understand and accept that LARA dental requires a minimum of 2 working days' notice for cancelling or rescheduling appointments. All appointments that are unattended will be charged a cancellation fee.

Patient/Parent/Legal Guardian Name:

Signature: Date: