GENTLE ENDODONTICS

CHATSWOOD
Level 3, Suite 301
10 Help Street,
Chatswood NSW 2067
T: 02 9411 3003
F: 02 9411 3006

DOUBLE BAY
Level 1, Kiaora Place,
451 New South Head Rd,
Double Bay NSW 2028
T: 02 9326 1399
F: 02 9411 3006

PARRAMATTA
Level 3, Suite 21, 27 Hunter St,
Parramatta NSW 2150
(Entry via O'Connell Street)
T: 02 9891 1610
F: 02 9891 1831

Dr Mehdi Rahimi Dental Specialist - Endodontist
BSc, BDS Distinction (NZ), DClinDent (Melb), FICD, FPFA, MRACDS, Adjunct Associate Professor (CSU

Dr Langley Tasmania Dental Specialist - Endodontist
BDS (Fiji), DClinDent (Otago)

Dr Garima Sharma Dental Specialist - Endodontist
BDS, DClinDent (Adelaide), MRACDS (Endo)

Dr Chankhrit Sathorn Dental Specialist - Endodontist
DDS, GradDipClinDent, DClinDent, PhD (Melb), MRACDS (Endo), Adjunct Professor (CSU)

Dr Muna Al-Ali Dental Specialist - Endodontist
BDS Distinction (UJ), MFDS (RCSI), DClinDent (UniMelb), FFD (RCSI)

NEW PATIENT MEDICAL AND DENTAL HISTORY FORM

Appointment date ____/____/_____

Patient's details

Title: Mr / Mrs / Ms / Miss / Dr Last name: _____

First Name: _____ Preferred Name: _____

Tel. Home: (___) _____ Tel. Work: (___) _____

Tel. Mobile: _____ E-Mail: _____

Date of Birth: ____/____/_____ Age _____ Occupation: _____

Patients Address

No.	Street	
Suburb	**State**	**Post Code**

Emergency contact

Name: _____ Relationship: _____ Phone number: (___) _____

Referring Dentist or Referral Source

Dentist name: _____

Dentist Tel. No: (____) _____ Tooth # Area to be treated _____

Medical History

Name of your GP: _____ GP's Phone No: (____) _____

GP's address (or suburb): _____

Have you ever had had any of the following? **Please tick those that apply.**

☐ High/Low blood pressure	☐ Diabetes
☐ Excessive bleeding, anemia or another blood disorder	☐ Sinus trouble
☐ Asthma or other respiratory problems (such as Chronic Obstructive Pulmonary disease/Emphysema/Bronchitis)	☐ HIV/AIDS
☐ Heart Murmurs	☐ Liver disease
☐ Prosthetic heart valve	☐ Kidney disease
☐ Pacemaker	☐ Jaundice
☐ Mitral Valve Prolapse	☐ Joint or organ replacement
☐ Congenital Heart Lesions	☐ Cancer, chemotherapy or radiation Therapy
☐ Rheumatic Fever	☐ Stroke, seizures or epilepsy
☐ Hepatitis A, B, C	☐ Neurosurgery or neurological disorders
☐ Fainting or dizziness	☐ Anxiety or psychological disorders
	☐ Other:

Have you ever taken any of the following medications? Please tick those that apply.

☐ Fosamax ☐ Aredia ☐ Bonefos ☐ Didrocal ☐ Didronel
☐ Pamisol ☐ Alendro ☐ Zometa ☐ Actonel ☐ Boniva
☐ Skelid ☐ Aclasta ☐ Bleomycin Sulfate ☐ Injections for Osteoporosis

Please indicate (tick) if you are allergic to any of the following.

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Sulpha Drugs ☐ Flagyl
☐ Nitrous-Oxide ☐ Erythromycin ☐ Valium ☐ Sedatives
☐ Steroids ☐ Ibuprofen ☐ Latex/Rubber ☐ Local Anesthetic (Novocain)

List any other drugs or medications you cannot take or are allergic to:

List any drugs or medications you routinely take:

(Women) Are You:

☐ Pregnant Now? ☐ Yes ☐ No ☐ Nursing? ☐ Yes ☐ No
☐ Taking Birth Control Pills? ☐ Yes ☐ No

Have you been hospitalised in the last two years? ☐ Yes ☐ No

Does dental treatment make you nervous?

☐ No ☐ Slightly* ☐ Moderately* ☐ Extremely*

Have you ever had the following for dental treatment?

Gas (Nitrous oxide/laughing gas) ☐ Yes ☐ No
Intravenous sedation ☐ Yes ☐ No
General Anesthesia ☐ Yes ☐ No

CONSENT FOR SERVICES

☐ I will assume responsibility for the fees associated with those procedures. I am aware that full payment is required on the day of treatment.
☐ I am aware that my health insurance policy will determine my eligibility and the rate of refunds for this treatment.
☐ I understand that the practice requires at least 48-hours notice if I need to cancel my scheduled appointment and that a **cancellation fee of $50.00** could be incurred if I fail to do so.
☐ I hereby consent the use of my x-rays, computer images and photographs may be sent to other dental practitioners (to aid with my treatment) or may be used at various dental or endodontic seminars, lectures, and publications that the endodontist may author.
☐ I have completed this questionnaire to the best of my knowledge and understand that failure to make full disclosure may place me at undue medical risk.

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