DENTAL WELLNESS DIMENSIONS

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MEDICAL AND

DENTAL

HEALTH EVALUATION FORM

Private & Confidential

Welcome to our Dental Practice.
Please complete this form to assist us in evaluating your treatment needs.

64 Chester Road, Bryanston , 2021
Tel. 011 463-1750 Fax. 011 463-0834

Surname: _____ **Date of Birth :** ___ /___/___

First Names : _____ **Title:** _____

I.D. Number :_____

Address : _____**Home Phone No. :**_____

_____ **Cell No. :**_____

_____ **Business Phone No. :**_____

Postal Code :_____ **E-mail :** _____

Occupation : _____ **Employer :** _____

Medical Aid :_____ **Number:** _____

Person Responsible for fees : _____

Address (if different from above) : _____

_____ **Post Code :** _____

Next of Kin : _____**Telephone :** _____

Recommended by: _____

MEDICAL / DENTAL HISTORY DETAILS

Do you or have you had any of the following? (Please tick)

	YES		YES
Heart Problems		**Allergies to:** Anaesthetics	
Heart Murmurs			
Prosthetic Heart Valves		Penicillin	
Blood Pressure		Other Medications Please specify:	
Rheumatic Fever			
Warfarin / Blood Thinners			
Circulatory Problems		**Blood Disorders**	
Nervous System Problems		Anaemia	
History of Cancer		**Diabetes**	
Radiation Treatment		**Asthma**	
Excessive Bleeding		**Hepatitis**	
Stomach Ulcer		**Epilepsy**	
Sinus Problems		**Liver or Kidney Problems**	
HIV/ AIDS		**Ladies are you Pregnant?** Due date: __/ __/ __	
Artificial Joint Replacements (hips, knees, etc)			

Are you currently taking any medication? Please list below.

Medication	Dosage	How often taken
1.		
2.		
3.		
4.		
5.		

The name of your medical Doctor: _____ Tel No. :_____

	YES	NO
Have you had trouble with previous dental experiences		
Does your jaw click or hurt		
Do you feel that you grind your teeth		
Do you have any areas between your teeth that trap food		
Have your teeth chipped ,worn down, or discoloured		
Do you wear a night guard		
Have you had orthodontic treatment (Braces)		
Do you like the colour of your teeth		
Do you like the arrangement of your teeth		
Do you like the shape of your teeth		
Do you have spaces between your teeth		
Does the appearance of your teeth bother you		
Do your gums look healthy		
Do your gums bleed when you clean your teeth		
Do you feel that you suffer from bad breath		
Have you had previous gum problems		

Previous Dentist's Name: _____
Previous X-rays:

Less than 1 year ☐ More than 1 year ☐

Please describe any concerns that you have about your teeth:

_____

_____

Acknowledgement of Immediate Payment Policy

- This practice has no agreement with any third party medical fund and fees are strictly payable on the day of the service being rendered
- Fees charged are private ie. **not** at the scale of benefits or "medical aid rate"
- We endeavour to keep fees as reasonable as possible while providing care of the highest quality; fees reflect our clinical time, quality materials and investment in equipment.

Thank you for taking the time to complete this form, the information you have provided will assist us to offer you the best comprehensive dental care

SIGNED: _____ **DATE**: __/