Stellar Dental Pty Ltd
Dr. Michael

Koller
Dental Surgeon
BDSc. LDS(Victoria)

Level 11, **Manchester Unity Building**
220 Collins Street, Melbourne VIC 3000
stellardental@westnet.com.au
Tel: 9650 9403 Fax: 9650 2562

PATIENT MEDICAL HISTORY

In order for this dental practice to provide the highest standard of care, it is requested you complete this form carefully and thoroughly.

Surname: .... **Title:** (eg. Mr/Mrs/Ms/other)..................................

Name: .... **Date of Birth:** ....

Home Address: .... **P/Code:** ....

Business Address: ....**P/Code:** ....

Occupation: ....

Phone: ....**Mobile:** ....**(BH)Ph:** ....**Fax:** ....

Email: ....

Postal Address (if different to above): ....

Emergency Contact: ....**Relationship:** ....

Address: ....**P/Code:** ....**Ph:** ....

Medical Doctor: .... **Ph**...

Private Health Insurance for Dental Treatment: Yes / No

Fund Name: ....**Membership #:** ....

Who recommended this practice to you? ....

WHAT DENTAL PROBLEMS- IF ANY- DO YOU HAVE?

Toothache	Δ	Sensitive Teeth	Δ
Bleeding Gums	Δ	Loose Teeth	Δ
Unsatisfactory Dentures	Δ	Rapidly Decaying Teeth	Δ
Lost filling – cavity	Δ	Grinding Clenching of Teeth	Δ
Worn/Broken Teeth	Δ	Pain in Face or Jaw Joints	Δ
Sounds/Clicking from Jaw	Δ	Difficulty/Discomfort when Chewing	Δ
Discolored Teeth/Fillings	Δ	Bad Breath	Δ

Is there anything you would like to change about your smile? NO Δ YES Δ

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

	NO	YES		NO	YES
High blood pressure	Δ	Δ	**Diabetes**	Δ	Δ
Heart ailment	Δ	Δ	**Thyroid problems**	Δ	Δ
Rheumatic fever	Δ	Δ	**Excessive Bleeding**	Δ	Δ
Asthma, chest or breathing problems	Δ	Δ	**Epilepsy**	Δ	Δ
Tuberculosis	Δ	Δ	**Hepatitis**	Δ	Δ
Stomach or bowel problems (eg ulcer)	Δ	Δ	**AIDS/HIV**	Δ	Δ

	NO	YES
Do you smoke? ***Yes/No*** **How many? ..../day Would you like to stop?**	Δ	Δ
Would you like to discuss these questions in private with the dentist?	Δ	Δ
Do you have: an artificial hip, heart valve or other prosthetic implant?	Δ	Δ
Have you ever had problems with dental treatment?	Δ	Δ
Are you presently under medical care?	Δ	Δ
Are you taking any drugs, medicines or tablets? (please list)............................	Δ	Δ
Females patients, are you pregnant?	Δ	Δ
Do you have allergies?	Δ	Δ
List any other previous illnesses	Δ	Δ

List any medicines or products you are allergic to (e.g. Penicillin, Latex): ....

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

Signed..Date...

On future visits any changes to the above should be advised.