CONFIDENTAL MEDICAL HISTORY

Your medical history may affect how we provide dental treatment safely for you. Your information will be handled in accordance with our privacy policy.

Title:…………… Name:…………...Date of Birth:……………………..….

Postal & Home address:…………………………………………………………….………Postcode…………….
Ph(hm):…………………………..Ph(wk):……………..…………Mobile:………………….…..……………..….
Email:…………………………………………………………………..…Occupation:………………………………
What language do you speak? ☐ English ☐ Other ………………………………………………..
Do you identify as Aboriginal or Torres Strait Islander? Y / N
How would you like to be contacted for appointment reminders?
☐ SMS ☐ Email ☐ Phone call ☐ None
Private Healthfund:…………………………………..……..
Emergency Contact:……………………………………..………Ph:……………….………………………….
How did you hear about us?…………………………………………………………….

Are you being treated by a doctor at present ? if yes, explain:……………………………………………….....
Who is your medical practitioner?…………………….……………………………….. Ph:…………………….....
Have you been hospitalized in the last 12 months? Y / N
Please list all current prescription medication or other tablets:
………...........
………..
Please list any **drugs** or medicines you are **allergic** to:…………………………………………………….
Please list any **other allergies** (eg latex):……………………………………………………..................

Please tick if you ever had or have now any of the following conditions

☐ Steriod therapy
☐ Diabetes
☐ Cancer
☐ Radiation therapy
☐ Stroke
☐ Excessive bleeding
☐ Abnormal reaction to local or general anaesthesia

☐ Bone disease (eg osteoporosis)
☐ High or low blood pressure
☐ Cardiac pacemaker
☐ Contact with blood borne viruses
☐ Hepatitis
☐ Rheumatic Heart Disease

☐ Epilepsy
☐ Heart Valve disorder
☐ Asthma/Lung disease
☐ Smoker
☐ Gastric reflux
☐ Snoring or Sleep Apnoea
☐ Ladies, are you pregnant?
Due date if yes:……………

Any other conditions not mentioned (please list):……………………………………………………
……………………………….……………………………………………………………………………

Financial consent

Person responsible for the cost of treatment …………………………………… Signature……………………..

Appointment policy: If you need to change your appointment with us, please give at least 24 hours notice, otherwise a cancellation fee may be incurred if you are unable to attend your appointment. Accounts must be paid in full on the day of treatment.

Patient or Guardian's signature: ………………………………………………… Date:…………………..………..