L&R DENTAL

CONFIDENTIAL 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:……..……..……

Suburb……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 Name and Number: ……..…… Reference number: ……

(Under 18's) Medicare: ……..…….. Reference number: ……

Emergency Contact: ……..……Ph: ……..…….

How did you hear about us?…….

Who is your medical practitioner/medical practice?……..……..

Are you being treated by a doctor at present? If yes, explain:……...

Have you been hospitalised 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 any of the following apply to you:

- ☐ Steroid therapy
- ☐ Radiation therapy
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Excessive bleeding
- ☐ Hepatitis
- ☐ Abnormal reaction to local or general anaesthesia
- ☐ Bone disease (e.g. osteoporosis)
- ☐ Prolia Injections
  Last Injection:.....
- ☐ High or ☐Low blood pressure
- ☐ Cardiac pacemaker
- ☐ Warfarin Tablets
- ☐ Heart Valve disorder
- ☐ Rheumatic Heart Disease
- ☐ Contact with blood borne viruses
- ☐ Epilepsy
- ☐ 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 48 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.

Signature: ……..…… Date:……..……