BURPENGARY DENTAL

YOUR SMILE WE CARE

Patient Medical History Form

We respect your privacy!
In accordance with the principles laid down in the privacy legislation and guidelines issued by the Australian Dental Association, all information inclosed on this form is confidential and will only be used by the treating dentist in order to deliver your care to the highest standards.

CONTACT INFORMATION

Surname: _____First Name: _____Title:_____

Date of Birth: _____ Email Address:_____

Postal Address: _____Suburb:_____Postcode:_____

Contact Numbers: (home) _____ (mobile) _____ (work) _____

Health Fund: _____

Next of Kin (in case of emergency) _____

Address: _____ Phone no: _____

How did you hear about us? *(Please circle)* Internet Facebook Word of mouth Drive by Other:_____

If referred, by whom: _____

MEDICATIONS / MEDICAL INFORMATION

☐*I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this.*

Do you normally require antibiotic cover before dental treatment?	YES / NO
Have you had any abnormal reactions to local or general anaesthesia?	YES / NO
Are you being treated by a doctor at present?	YES / NO
Have you been hospitalised in the last 12 months?	YES / NO
Have you or anyone in your household returned from overseas travel in the last 10 days?	YES / NO
Do you smoke?	YES / NO
Are you pregnant? How many weeks? ☐	YES / NO
Who is your medical practitioner? ☐ Ph: ☐	
ALLERGIES:	
Latex	YES / NO
Penicillin	YES / NO
Other antibiotic *Please specify:*	YES / NO
Codeine	YES / NO
Other allergies *Please specify:*	YES / NO

Please list Medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE TURN OVER

MEDICAL CONDITIONS

Please circle YES or NO if you have or have ever had any of the following medical conditions

Rheumatic Fever	YES / NO	Hepatitis B, C or HIV	YES / NO
High blood pressure	YES / NO	Contact with blood-borne viruses	YES / NO
Low blood pressure	YES / NO	Thyroid disease	YES / NO
Cardiac Pacemaker	YES / NO	Diabetes	YES / NO
Stroke	YES / NO	Kidney disease	YES / NO
Asthma	YES / NO	Epilepsy	YES / NO
Steroid therapy	YES / NO	Cancer	YES / NO
Tuberculosis	YES / NO	Radiation therapy	YES / NO
Excessive bleeding	YES / NO	Nervous or psychiatric condition	YES / NO
Stomach or digestive condition	*Please specify:*		YES / NO
Liver disease	*Please specify:*		YES / NO
Heart disease / complaint	*Please specify:*		YES / NO
Prosthetic implant (eg. artificial hip)	*Please specify:*		YES / NO
Bone disease (eg. osteoporosis)	*Please specify:*		YES / NO
Bronchitis ☐ Emphysema ☐	other lung disease:		YES / NO
Anaemia ☐ Leukaemia ☐	other blood disease:		YES / NO

Do you have any other diseases, conditions, or problems not listed above that you think we should know about?

_____

_____

CONSENT FOR SERVICES

☐ Please tick the box if you consent to Burpengary Dental using images of your teeth for marketing purposes. *Images taken will be of the mouth only; Faces and names will not be included. Images may be used on our website, Facebook or in-surgery photo album.*

I give my authority for any treatment agreed up on by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatment.
I understand that it is the policy of the practice for all treatment to be paid for at the time of the appointment or in advance. I shall pay any legal costs incurred by the practice as a result of my failure to pay any amounts due. I understand that failure to attend an appointment or cancel my appointment within 24 hours, I will incur a fee of $25 per 15 minutes.

Returning patients only;

☐ I, _____ (full name), acknowledge all questions and information on both sides of this form and confirm there are no changes or additions to my contact information or medical history.

Signature: _____ Date: _____

(Parent/guardian needs to sign if patient is under 18 years)

Parent/guardian name: _____ *Relationship to patient:* _____