Medical History Form

Title (Circle): Dr Mr Mrs Ms Miss Last Name: ____________________

Date of Birth: ______ /______ /______ First Name: ____________________

Phone # - Home: ____________________ Mobile: ____________________ (SMS reminders will be sent to mobile)

Home/Postal Address: ____

Occupation: ____________________ Email Address: ____________________

Emergency Contact - Name: ____________________ Relationship: ______________ Phone: ______________

Do you have Private Health Insurance with extras cover for dental? ○ YES ○ NO

IF YES - Insurer: ____________________ Member #: ____________________ Customer #: ______

0-18 years ONLY - Are you eligible for the Child Dental Benefit Schedule? Medicare #: ______________ Ref #: _____

Are you a Gold Card Veterans Affairs client? ○ YES ○ NO | IF YES - DVA Number: ____________________

Medical Practitioner: ____________________ Clinic: ____________________ Phone: __________

Please list any known allergies/reactions (including drugs, latex, foods, etc): ____________________

____

Please list current medications and injections: ____________________

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	YES	NO
Have you been advised to take antibiotics prior to dental treatment?	○	○
Have you had abnormal reactions to Local Anaesthetic?	○	○
Do you smoke?	○	○
Are you pregnant?	○	○

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	YES	NO
Anaemia	○	○
Anxiety	○	○
Artificial Joints	○	○
Asthma	○	○
High blood pressure **(OR)**	○	○
Low blood pressure	○	○
Bone Disease (incl osteoporosis)	○	○
Bronchitis	○	○
Cancer/Tumors	○	○
Cardiac Pacemaker	○	○
Contact with blood-bourne viruses	○	○
Diabetes - Type 1 **(OR)**	○	○
Diabetes - Type 2	○	○
Emphysema or other lung conditions	○	○
Epilepsy	○	○

	YES	NO
Excessive Bleeding	○	○
Heart Disorder/Complaint	○	○
Hepatitis - A B C D E (please circle)	○	○
Kidney Disease	○	○
Leukemia or other blood diseases	○	○
Liver Disease	○	○
Nervous/psychiatric condition	○	○
Radiation Therapy	○	○
Rheumatic Fever	○	○
Sinus Problems	○	○
Steroid Therapy	○	○
Stomach/Digestive condition	○	○
Stroke	○	○
Thyroid Disease	○	○
Tuberculosis	○	○

Please list any other conditions/hospitalisations/surgeries: ____________________

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The information you provide is confidential and will be handled in accordance to our Privacy Policy.

Patient Declaration - I hereby declare that the information provided on this form is true and correct.

Cancellation Policy - Please be aware we require 24hrs notice for rescheduling an appointment and if adequate notice is not given a cancellation fee may apply.

By signing this form, you consent to being recorded for security purposes while in the practice.

Your / Your Guardian's Signature:______________________________ **Date:** _____ **/**_____ **/**_____