123Dental

CONFIDENTIAL MEDICAL HISTORY FORM

Name ______________________________ ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

Address ______________________________ Suburb ______________

Date of Birth ______________ Phone (Home) ______________ Mobile ______________

Email ______________ Occupation ______________ Employer ______________

Emergency Contact: ______________ Relationship: ______________ Contact No: ______________

Health Fund Name ______________ Membership number ______________

How did you hear about us? ☐ Google ☐ Facebook ☐ Flyer ☐ Word of Mouth ☐ Other ______________

What is the name of your GP or specialist? ______________________________

When did you last visit a dentist? ______________________________

Please list any medications you are currently taking, including over the counter and herbal medicines

____

Do you have any allergies? ☐ Yes ☐ No If Yes, list them below:

____

Have you ever had any of the following conditions?

	Y	N
Heart Condition		
Heart Surgery		
Rheumatic Fever		
High/Low Blood Pressure		
Anticoagulant (Blood Thinning) Medication		
HIV or Aids		
Cancer Type: -		
Chemo or Radiotherapy		
Excessive Bleeding or Bruising		
Osteoporosis		
Bisphosphonate Treatment		
Joint Replacement Year: -		
Diabetes Type: -		
Family History of Diabetes		

	Y	N
Hepatitis Type: -		
Tuberculosis		
Depression/Anxiety Disorder		
Epilepsy		
Thyroid Disease		
Asthma		
Gastric Ulcer		
Cold Sores		
Do you smoke? (If so, how many a day?)		
Dry Mouth		
Snoring or Sleep apnoea		
Do you grind your teeth?		
Are you Pregnant?		
Are you Breastfeeding?		

Would you like to discuss any of the following with your dentist?

☐ Tooth whitening
☐ Implants
☐ Orthodontics treatment (braces) including invisalign
☐ Any other dental treatment

I confirm that this information is an accurate representation of my medical history. I understand that all information will be treated with professional confidentiality. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made and that I may incur a $100 fee for missed appointments or cancellations with less than 24 hours notice.

Patient Signature ______________ Date ______________ Reviewed ______________

(If under 18 yrs. old parent/guardian to sign and complete below)

Parent / Guardian ______________ Date ______________ Reviewed ______________