Medical History Form

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

Date of Birth: ____/_____/_____ First Name: ________________________________

Home/Postal Address: ____ Postcode: ______

Phone Numbers H:____________________ M:_____________________ (SMS reminders will be sent to this number)

Email Address: ____

Emergency Contact - Name: ______________________ Relationship:__________________ Phone:__________________

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

IF YES - Insurer:___________________________ Membership #:______________________ Customer #: ________

Are you a Veterans Affairs client? YES / NO IF YES - DVA Number: ___________________________

Who is your Medical Practitioner?: ____Phone: ________________

Please list any known allergies/reactions (incl. drugs, latex, foods etc): ____

____

Please list current medications and injections: ____

____

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

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

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

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

Any other conditions/hospitalisations/surgeries (please list):____

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 that we require 24hrs notice for rescheduling an appointment and if adequate notice is not given a cancellation fee may apply.

Your/Guardian's Signature:_______________________________________ Date: ___________________

Staff Use Only - Entered______ Scanned______