

## Confidential Patient History

Title: Mr Mrs Ms Miss Master Dr First Name: \_\_\_\_\_  
Surname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Postal Address (if different to above) \_\_\_\_\_  
\_\_\_\_\_ Post Code: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Daytime phone: \_\_\_\_\_ Person responsible for fees: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Preferred method of contact:  Letter  Email  SMS/ Telephone  
Medical Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_  
How did you find out about the practice: (Please tick)  Current patient/ Friend  
 Local paper  Internet  Sign  Yellow Pages  Other \_\_\_\_\_  
When was your last dental visit: \_\_\_\_\_  
Do you have Dental Insurance? If yes with who?: \_\_\_\_\_  
Are you aware of our HICAPS machine that enables people with Dental Insurance to claim at the practice.

## Confidential Medical History

*Please tick if you have had:*

High/Low Blood Pressure	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Heart Ailment	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Excessive Bleeding or	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>
Stomach or Bowel Problems	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
AIDS / HIV	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>		

Do you have any allergies: \_\_\_\_\_  
Please list any other previous illnesses: \_\_\_\_\_  
Do you have an artificial hip/ heart valve/ or prosthetic implant: \_\_\_\_\_  
Are you currently taking any medication: \_\_\_\_\_  
Are you currently receiving any medical treatment YES / NO  
Ladies, is there any chance that you are pregnant YES / NO

Are you aware of our payment on the day policy? We request and expect payment at the time of treatment. For your convenience we accept Cash, Cheques, Eftpos and Visa, Master Card and Bank Card.

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I also understand that, notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid in my dental treatment and consent to this.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_