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CONFIDENTIAL PATIENT DETAILS & MEDICAL/DENTAL HISTORY

NAME: Mr
Mrs _____
Miss Surname Given Name(s)
Ms

DATE OF BIRTH _____

IS ANY OTHER PERSON(S) RESPONSIBLE FOR ACCOUNTS PAYABLE YES/NO
IF YES, PLEASE ADVISE _____

RESIDENTIAL ADDRESS _____
_____ **Postcode** _____
POSTAL ADDRESS _____
_____ **Postcode** _____
TELEPHONE Home _____ **Work** _____
Mobile _____

NAME OF HEALTH FUND _____
HEALTH FUND MEMBERSHIP NUMBER _____

LEVEL OF HEALTH COVER (Please tick): PRIVATE HOSPITAL _____ **EXTRAS/DENTAL** _____
NO HOSPITAL _____ **NO DENTAL** _____

MEDICARE NUMBER _____ **(Ref #** _____ **)**

MEDICAL HISTORY (Please circle)

Are you under the routine care of a Medical Practitioner ? YES/NO
If Yes, name of Practitioner _____

Are you **ALLERGIC** to any medications, foods etc? YES/NO
If Yes, what are they? _____
_____

Do you normally require antibiotic cover before Dental/ Surgical treatment ? YES/ NO

P.T.O. continued

Have you now, or in the past, had any of the following ailments:-

Cardio-vascular Problems (eg Heart Disease, Angina, heart valve etc) YES/NO

Respiratory Problems (eg Asthma etc) YES/NO

Blood Pressure Problems YES/NO

Bleeding Disorders YES/NO

Rheumatic Fever YES/NO

Diabetes YES/NO

Epilepsy YES/NO

Hepatitis YES/NO

Nervous / Anxiety conditions YES/NO

Prosthetic or other implant, (eg artificial hip, shunt) YES/NO

Bisphosphonate medication (eg, Fosamax, for osteoporosis) YES/NO

Contact with AIDS / HIV / Hepatitis Virus YES/NO

Are you taking any medications at present? YES/NO

If Yes, please list (if significant medications prescribed, then it is preferable for you to supply a Medical/Health Summary from your Doctor/Physician)

_____

_____

Are you pregnant? YES/NO
If Yes, when is your due date? _____

Are there any OTHER SERIOUS MEDICAL PROBLEMS/ILLNESSES you have experienced in the past or at present? YES/NO
If Yes, then please list below and discuss with Nursing Staff.

_____

Have you ever had a General Anaesthetic ? YES/NO
If Yes, any problems? _____

Have you ever had Local Anaesthetic (eg numbing dental injections) ? YES/NO
If Yes, any problems? _____

Have you ever had Radiotherapy Treatment to the Head/Neck/Facial regions? YES/NO

PATIENT or PARENT/GUARDIAN ACKNOWLEDGEMENT/CONSENT

I UNDERSTAND THAT IT IS THE PRACTICE POLICY TO FORWARD ALL PROLONGED OUTSTANDING ACCOUNTS TO A COLLECTION AGENCY/SOLICITOR, & ANY ASSOCIATED COSTS WILL BE ADDED TO THE PATIENT ACCOUNT.
I ACKNOWLEDGE THAT THE INFORMATION PROVIDED IS TRUE/CORRECT TO THE BEST OF MY KNOWLEDGE.
I CONSENT TO PERSONAL INFORMATION RELATING TO CURRENT & FUTURE MEDICAL/SURGICAL TREATMENT TO BE DISCLOSED TO OTHER RELEVANT MEDICAL/DENTAL PRACTITIONERS, HOSPITALS OR HEALTH SERVICE PROVIDERS.

SIGNATURE OF PATIENT or PARENT/GUARDIAN _____

DATE _____