adelaidedentalsolutions

MEDICAL HISTORY FORM

Your Personal Details:

Gender : Male / Female Title : DOB :

First Name : Surname :

Postal Address :

Suburb : Postcode :

Mobile # : Home # : Work # :

Email Address : Occupation :

Nationality : Would You Like To Be Added To Our Mailing List : YES / NO

Name of Health Fund : Family Member ID # :

Best Confirmation Method for Appointments (please circle): SMS TELEPHONE EMAIL

Person to contact in case of emergency _____

Relationship: _____ Phone Number: _____

How did you hear about us?

Flyer Our Website Local Paper Yellow Pages Health Fund Driving Past

Referred By (Who?) _____

Information about your Medical/Dental history:

When Was Your Last Dental Treatment Approximately? _____

Last Dental Cleaning? _____ Last Full Mouth X-Rays? _____

Do You Feel Nervous About Your Dental Treatment? _____

GP Name: _____ Phone # _____

Are You Currently Undergoing Any Medical Treatment Or Had Any Surgery Within The Last 12 Months : Yes / No

Are You Taking Any Medication, Drugs Or Pills Now? Yes / No
If Yes, Name Medication And Dosage: _____

_____

Are You Taking Any Biphosphonate Medications? Eg: Actonel, Fosamax, Disodium Pamidronate, Other?

_____

Do You Have Any Allergies? Eg: Penicillin, Aspirin, Erythromycin, Milk-Protein, Other?_____

_____

Please Indicate Below If You Have Had, Or Have At Present Any Of The Following. Circle 'Yes' Or 'No'

Female: Are You Pregnant or Breast Feeding	Y / N	Crohn's Disease	Y / N
Smoker	Y / N	Stomach Ulcers	Y / N
Have / Having Botox	Y / N	Thyroid Problems	Y / N
Heart Disease/Attack/Surgery	Y / N	Diabetes	Y / N
Heart Pacemaker	Y / N	Stroke	Y / N
Artificial Heart Valve	Y / N	Tuberculosis	Y / N
Sjrogren's Syndrome	Y / N	Haemophilia	Y / N
Joint Replacement (Hip, Knee etc.)	Y / N	Emphysema / Chronic Cough	Y / N
Bone Disease	Y / N	Blood Pressure (High / Low)	Y / N
Cancer_____	Y / N	Latex Sensitivity	Y / N
Chemotherapy/Radiation	Y / N	CJD	Y / N
Asthma	Y / N	Osteoporosis	Y / N
Fainting / Dizzy Spells	Y / N	Arthritis	Y / N
Epilepsy	Y / N	Rheumatoid	Y / N
Sinus / Hay Fever	Y / N	Hepatitis A / B / C	Y / N
Rheumatic Fever	Y / N	HIV / AIDS	Y / N

Other _____

We request and expect payment at the time of treatment. For your convenience we accept cash, cheques, eftpos, all major credit cards. Also note that you are responsible for any costs incurred by our practice for recovery of outstanding payments. I understand that payment of the account is my responsibility, and that my Health Fund (if any) will not cover the full amount. I undertake to pay any expenses incurred or to be incurred in the collection of any overdue portion of this account.

Patient / Guardian Signature _____ Date _____