PATIENT DETAILS

MEDICAL HISTORY

Preferred Title: Dr / Mr / Mrs / Ms / Miss / Master / Other: .....

Surname Name:..... First Name:..... Preferred Name:.....

Address:..... Suburb:..... PC:.....

Phone: (H)..... (W) ..... Mobile:.....

Date of Birth:...../...../..... E-Mail:.....

Occupation:..... Do you have Dental Insurance? Y / N

If so, Health Fund Name: ..... Card Number:..... ID#.....

Are you a member of smile.com.au? Yes or No (Please circle)

*Is your child eligible for Medicare Child Dental Benefit Scheme? Y / N

If so, Medicare Number: ..... Card ID .....

Emergency Contact Name:.....Relationship:.....

Contact Number:.....

To complete only if patient is under 18 years old: (Responsible Person for Account)

Guardians Name:..... Contact Phone #:.....

Guardians address, if different:.....

Please indicate (circle) below if you have any of the following conditions:

Stroke	Y / N	Thyroid Problems	Y / N	Emphysema	Y / N
Artificial Heart Valve	Y / N	Diabetes	Y / N	Artificial Joints	Y / N
Chest Pain	Y / N	Tuberculosis	Y / N	Cancer	Y / N
High Blood Pressure	Y / N	Heart Murmur	Y / N	Haemophilia	Y / N
Low Blood Pressure	Y / N	Heart Pacemaker	Y / N	Asthma	Y / N
Sinus Problems	Y / N	Rheumatic Fever	Y / N	Hepatitis A, B or C	Y / N
Epilepsy	Y / N	Bleeding Disorder	Y / N	HIV / AIDS	Y / N
Mental Disability	Y / N	Osteoporosis	Y / N	Stomach Ulcers	Y / N
Heart Disease	Y / N	Arthritis / Rheumatism	Y / N	Hay Fever	Y / N

Details:.....

.....

Have you been hospitalized in the last 5 years (Give reason).....

.....

PLEASE TURN OVER

Have you any known **Allergies**?.....

……..

Please list ALL medication you are currently taking:

……

……..

General Practitioner: …… Practice Name: ……
Location: …… Phone Number: ……..

Are you pregnant? (Female) Y / N If yes, …….. Breastfeeding? (Female) Y / N

Smoker? Y / N

On a scale of 1 – 10 how anxious are you about dental treatment?.....
1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (10 is very anxious)

Signature:…… Date:……

Thank you for your time to fill in your history; this allows us to give you the best possible care.

I consent to: (please tick if agree)

- I have completed this questionnaire to be the best of my knowledge and understand that failure to make full disclosure may place me at undue risk.
- I authorize to have photographs taken of my face and teeth and understand that these photographs will be used as a record of my care.
- I (do/do not) consent to my photographs being used for educational purposes in lectures, demonstrations to other patients, marketing efforts to include publication, website and professional publications.
- I further understand that if the photographs are used, my name and other identifying information will be kept confidential.

  I do not expect compensation, final or otherwise, for the use of these photographs.

Signature:……Date:……..

**In compliance with federal and state privacy legislation the information will be treated with complete professional confidentiality. For further information, please ask for a copy of our privacy policy.*

Please Note: Policy at this practice is for payment to be made on the day of treatment, any outstanding 'long term' accounts will be sent to a Debt Collection Services at your expense.

On your future visits, any changes to the above should be advised.

*Our practice requires a minimum of **24 hrs notice for cancellations**. The practice reserves the right to charge per half on hour should sufficient notice not be given or if failed to attend appointment.*

From all the team at our dental surgery we would like to welcome you to our practice and thank you for choosing us as your dental provider. Our aim is to provide each patient with optimal dental treatment.