

**SALE FAMILY DENTIST PATIENT HISTORY SHEET**

*In order for this dental practice to provide the highest standard of care, it is requested that you fill in this form carefully and thoroughly.*

Title: Miss/Mrs/Ms/Mr/Dr (Please circle) Surname: \_\_\_\_\_  
Given Name/s: \_\_\_\_\_ Date of Birth: \_\_ / \_\_ / \_\_\_\_  
Home Address: \_\_\_\_\_ Business Address: \_\_\_\_\_  
\_\_\_\_\_ Postcode: \_\_\_\_\_ \_\_\_\_\_ Postcode: \_\_\_\_\_  
Postal Address (if different to above): \_\_\_\_\_  
Email: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Name of Person responsible for fees: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical Doctor/Clinic: \_\_\_\_\_  
Are you covered by private health for dental? Yes / No Fund Name: \_\_\_\_\_

*NOTICE TO INSURED PATIENTS REGARDING DENTAL BENEFITS INSURANCE*

Item numbers on our statements represent as accurately as possible the procedures performed, but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures to attract refunds, and the rates, are determined by the conditions of the patient's Health Insurance Policy. We accept no responsibility, to either party for any decision the insurer may make regarding the refund of monies to the patient.

**HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE:**

	YES	NO		YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type 1/2	<input type="checkbox"/>	<input type="checkbox"/>
Heart ailment	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, chest or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy/Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>

If yes to chemotherapy/radiotherapy, where on the body & when? \_\_\_\_\_

List any other **previous illnesses**: \_\_\_\_\_

Have you had: **joint replacements, heart valve** or any **other surgical procedures**? Year? \_\_\_\_\_

List any problems with previous dental treatment e.g. Dry socket? \_\_\_\_\_

Are you presently under medical care for any medical condition? \_\_\_\_\_

Are you taking any **drugs, medicines** or **tablets**? (Please list) \_\_\_\_\_

Female patients, are you pregnant? Yes/No Gestation: \_\_\_\_\_

Do you have **allergies**? Yes/No

List any **medicines** or **products** you are **allergic** to e.g. **Penicillin, Latex** \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

*THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE*

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 understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check-up reminders.

Signed: \_\_\_\_\_

Date: \_\_ / \_\_ / \_\_\_\_

**ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED**