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.

Surname.. First Name...

Title: Miss/Mr/Mrs/Ms/Other:.............................Date of Birth:..

Home Address:..Suburb...............................P/Code:...............

Business Address:.. P/Code:.............................

Home Ph:................................. Mobile:..................................Work Ph:...............................

Email...

Postal Address (if different to above): ....

Name of Person responsible for fees: ....

Address (if different from above): ....

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

Address:... Ph:..

Medical Doctor/Clinic: ....

Private Health Insurance Name...................................... Member number & ID....................................

NOTICE TO INSURED PATIENTS REGARDING DENTAL BENEFITS INSURANCE

Item Numbers on our statements represent as accurately as possible the procedure 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	☐	☐	Heart Ailment	☐	☐
Rheumatic Fever	☐	☐	Asthma Chest or Breathing problems	☐	☐
Tuberculosis	☐	☐	Stomach or bowel problems	☐	☐
Kidney disease	☐	☐	Diabetes	☐	☐
Thyroid problems	☐	☐	Excessive bleeding or blood disorder	☐	☐
Epilepsy	☐	☐	Hepatitis	☐	☐
AIDS/HIV	☐	☐	Cancer	☐	☐
Do you smoke?	☐	☐	How many? __/day Would you like to stop?	☐	☐
Osteoporosis	☐	☐	Radiotherapy-if yes where on body?	☐	☐

List any other previous illnesses: ....

Would you like to discuss these questions in private with the dentist? ....

Do you have: an artificial hip, heart valve or other prosthetic implant? ....

Have you ever had problems with dental treatment? ....

Are you presently under medical care for any medical condition? ....

Are you taking any drugs/medicines/ tablets? Please list: ....

Female patients, are you pregnant? ....

Do you have allergies? ....Please list any medicines/products you are allergic to: (eg Penicillin, <u>**Latex**</u>):

....

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