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/Master/Mr/Dr (Please circle) Surname: _____
Given Name/s: _____ **Date of Birth:** ____/____/_____
Home Address: _____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: _____
Private Health insurance for dental? Yes/No Fund Name:_____

Member Number:_____ Individual Number:_____

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.

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

	YES	NO		YES	NO
High blood pressure	☐	☐	Diabetes Type 1/2	☐	☐
Heart ailment	☐	☐	Thyroid problems	☐	☐
Rheumatic fever	☐	☐	Excessive bleeding or blood disorder	☐	☐
Asthma, chest or breathing problems	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
Stomach or bowel problems	☐	☐	AIDS/HIV	☐	☐
Kidney problems	☐	☐	Do you smoke?How many a day? _____	☐	☐
Arthritis	☐	☐	Cancer	☐	☐
Osteoporosis	☐	☐	Chemotherapy/Radiotherapy	☐	☐

If **yes** to cancer/chemotherapy/radiotherapy, where on the body & when? _____
List any other **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:**____wks____days **Due Date:**____/____/_____
Do you have **allergies**? Yes/No Please list 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