



MEDICAL/DENTAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy which is shown on the reverse of this form.

Title (eg Mr/Mrs/Ms):	Last Name:		
Date of birth:	First name(s):		
Home address:		Postcode:	
Postal address:		Postcode:	
Ph (hm):	Ph (wk):	Mob:	Email:
Name of emergency contact person:			Their Phone No:

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this (please tick box).

	No	Yes	List Medications:
Do you normally require antibiotic cover before dental treatment?			
Have you had any abnormal reactions to local or general anaesthesia?			
Do you smoke?			
Are you pregnant? (Females only)			
Are you being treated by a doctor at present?			
Are you taking <u>any</u> prescription or other medications at present?			
Have you been hospitalised in the last 12 months?			
Have you or anyone in your household returned from overseas travel in the last 10 days?			

Please list current medications:

Who is your medical practitioner? Ph:

Please list any drugs or medicines you are allergic to:

Please list any other known allergies (including latex, foods and preservatives):

**DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please tick either yes or no for each condition**

	No		Yes			No		Yes	
Steroid therapy			Kidney disease			Prosthetic implant eg artificial hip			
Rheumatic fever			Excessive bleeding			Cardiac pacemaker			
Epilepsy			Stroke			Stomach or digestive condition			
Asthma			Cancer			Hepatitis or other liver diseases			
Diabetes			Tuberculosis			Contact with blood-borne viruses			
Heart disorder/complaint			Thyroid disease			Bronchitis, emphysema or other lung diseases			
Bone disease, including osteoporosis			Nervous or psychiatric condition			Anaemia, leukaemia or other blood diseases			
Radiation therapy			High or low blood pressure			Any other conditions			

Any other condition(s) not mentioned (please list):

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

I have read and accept the privacy policy on the reverse of this form.

Your / Guardian's signature: Date:

OFFICE USE ONLY Reviewed by: (please print name) Signature: Date:



WE RESPECT YOUR PRIVACY

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number but it is also necessary for the dentist to obtain from you details regarding your general health and past medical or surgical events. Without this general health picture, the treating dentist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- ❖ This information will only be used by the treating dentist in order to deliver your care to the highest standards.
- ❖ It will not be disclosed to those not associated with your treatment without your consent except as provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information.
- ❖ You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times.
- ❖ There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.
- ❖ We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date.
- ❖ We will take reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure.
- ❖ Our staff are trained to respect these principles at all times.

If you have any questions regarding the information we collect from you and hold in your dental records, please do not hesitate to ask us. We are acting in your interests at all times.