MEDICAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of your dental treatment. The information you provide is confidential and is available on request.

Full Name: ..... *Date of Birth: .....*

Email Address: .....

Address (including post code): .....

Home Number: ..... *Mobile Number: .....*

Do you have private health (if yes, please specify name): ....

Emergency Contact (Name and contact): .....

How did you hear about us? (Friends, family, online, if other please specify).....

Have you had any of the following illnesses?

Rheumatic Fever	*Yes / No*	*Diabetes*	*Yes / No*
Heart Disease	*Yes / No*	*Epilepsy*	*Yes / No*
Heart Murmur	*Yes / No*	*HIV*	*Yes / No*
Prosthetic Heart Valve	*Yes / No*	*Anxiety/Depression*	*Yes / No*
Cardiac Pacemaker	*Yes / No*	*Kidney Disease*	*Yes / No*
High/Low Blood Pressure	*Yes / No*	*Blood Disorders*	*Yes / No*
Stroke	*Yes / No*	*Excessive Bleeding Disorder*	*Yes / No*
Hepatitis or Liver Disease	*Yes / No*	*Thyroid Disease*	*Yes / No*
Asthma	*Yes / No*	*Osteoporosis/Bone Disorders*	*Yes / No*
Snoring/Sleep Apnoea	*Yes / No*	*Radiation Therapy*	*Yes / No*
Cancer	*Yes / No*	*Prosthetic Artificial Joints*	*Yes / No*
Stomach or Digestive Condition	*Yes / No*	*Bleeding or Clotting Disorders*	*Yes / No*

Any other medical conditions we need to be aware of? (Ladies are you pregnant).....

Have you been hospitalized in the last 12 months, if yes please specify the reason?.....

Are you receiving any Medical Treatment, if yes please specify?.....

Please list any allergy's e.g. Drugs, food, latex.....

Please list any medications you are currently taking: ..... ***P.T.O***

When was your last dental visit? .....

Do you require antibiotic cover before dental treatment? *YES/NO*

Do you smoke or have you smoked in the past? *YES/NO*

Are your teeth sensitive? *YES/NO*

Does your jaw click or hurt? *YES/NO*

Do you have any other dental issues, if yes please specify?

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Consent for Treatment

- *I confirm that the information I have provided on this form is correct*
- *I hereby authorise the dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me.*
- *I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents has certain risks. I understand I can ask for complete recital of possible complications.*
- *I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.*
- *I understand in the event of non-payment my account will be forwarded to a debt collection agency and I would be liable to pay any collection fees thus incurred*
- *I authorise that this data may be reviewed by team members of the dental practice.*
- *I understand that a minimum of 48 hours notice for cancellations is required, a small fee may apply for late notice and/or missed appointments*

Name: *.....* ***Day:*** *.....*

(Guardians of patients under 18 need to provide

their name and signature)

Sign: *.....* ***Date:*** *.....*