Medical/Dental History Form

PRIVATE AND CONFIDENTIAL

It is important for your Dentist to know your medical history so that we can provide treatment safely for you. Please provide full details regardless of how irrelevant they may seem.

Title:	First name(s):	Last name:
Date of birth:	Preferred name:	Occupation:
Home address:		
Postal address (if different):		
Preferred Phone Number:	Email:	Preferred method of contact: ☐ Phone Call ☐ Email ☐ SMS
Name of emergency contact:	Phone:	
Who is your medical practitioner/ GP / Doctor's Clinic?	Address / Phone (if known):	
Do you have health insurance which includes dental cover? ◯ Yes ◯ No	Name of fund:	
How did you find out about Dr Rachael McDonald and/or our clinic? ☐ Patient ☐ Friend ☐ Internet ☐ Social Media ☐ Advertisement ☐ Road sign Other:		
If not our clinic, when did you last visit a Dentist?	Name of Dentist / Dental Practice (if known):	

I have additional confidential medical information that I do not wish to write down. I would prefer to speak directly to the Dentist about this. **No** ◯ **Yes** ◯

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. We value the need to safeguard this information and, in accordance with principles laid down in the Privacy Act and guidelines issued by the Australian Dental Association and our Privacy Policy.

Terms of Payment

I accept responsibility for my account and understand that the fee is payable on the day. Should I be unable to pay on the day I understand the payment is due within 30 days; if my account exceeds 30 days I understand an account keeping fee will be incurred. If my account remains overdue and is referred to a debt collection agency or solicitors, I may be held liable for the costs of such collection plus interest. I accept full responsibility for health fund claims and rejections. Any fees incurred by the practice for cheques not accepted by the bank will be passed to me.

I declare that:

- I have read the privacy statement above and have accurately completed this form
- I consent to the performing of dental surgery procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures
- I am aware that payment is required on the day of treatment and I agree to settle my account on that day

Patient/guardian signature: Date:	Office use:

MEDICAL HISTORY

Do you have now, or have you ever had, any of the following medical conditions?
Please tick either 'No' or 'Yes' for each condition

	No	Yes	Unsure
Are you being treated by a doctor at present?	○	○	○
Are you taking any prescription or over-the-counter medications at present?	○	○	○
Have you been hospitalized in the last 12 months?	○	○	○
Do you have a medical requirement for antibiotic cover before dental treatment?	○	○	○
Have you had any unusual reactions to local or general anaesthesia?	○	○	○
Do you have any allergies, eg penicillin, sulphur, latex, foods?	○	○	○
Are you pregnant?	○	○	○

If you drink alcohol, how much do you drink: per day/week/month?

How much do you smoke/vape: per day/week? Years smoked/vaped? Approx date if quit:

Do you have Osteoporosis or bone disorder/metastases?	○	○	○
If so, have you ever required medications, eg: Osteoporosis Injections and Tablet's (Didronel, Bonefos, Fosamax, Alendro, Actonel, Skelid, Aredia, Amisol, Zomet)	○	○	○
Do you have any cardiac history, trouble with your heart or heart valves?	○	○	○

	No	Yes
Heart Disorder/condition	○	○
Rheumatic Fever	○	○
Cardiac Pacemaker / internal defibrillator	○	○
High Blood Pressure	○	○
High Cholesterol	○	○
Stroke	○	○
Blood thinners or bleeding/blood disorder	○	○
Arthritis	○	○
Back or neck problems	○	○
Steroid Therapy	○	○
Asthma	○	○
Respiratory/Lung Disease/Bronchitis/Emphysema/TB/other	○	○
Sleep disturbances/apnoea	○	○
Do you use any type of dental appliance, eg mouthguard, denture, night guard?	○	○

	No	Yes
Diabetes Type 1 or 2	○	○
Reflux	○	○
Digestive/bowel disorder	○	○
Epilepsy	○	○
Kidney disease	○	○
Hepatitis A/B/C	○	○
Thyroid disorder	○	○
Cancer	○	○
Chemotherapy	○	○
Radiation therapy	○	○
Contact with HIV/AIDs	○	○
Joint replacements (Knee, Hip) If yes, date:	○	○
Nerve or Neurological condition	○	○
Any other conditions not included above:		

MEDICATIONS

There are many medications that may impact upon your oral health or the treatment we may suggest for you. Please list your medications

	Dosage	Purpose / Condition	Duration of treatment
Medication name:			
Medication name:			
Medication name:			
Medication name:			