Bli Bli Dental

CONFIDENTIAL MEDICAL HISTORY

IT IS IMPORTANT TO KNOW DETAILS ABOUT YOUR MEDICAL HISTORY AS THESE COULD IMPACT YOUR DENTAL TREATMENT.

THE INFORMATION YOU PROVIDE IS CONFIDENTIAL AND WILL BE HANDLED IN ACCORDANCE WITH PRIVACY REGULATIONS.

TITLE: MR / DR / MRS / MS / MISS | **FIRST NAME:** | **LAST NAME:**

DOB: / / | **PHONE:** | **EMAIL:**

HOME ADDRESS:

CONTACT IN CASE OF EMERGENCY: NAME: PHONE: RELATIONSHIP TO YOU:

ARE YOU IN A HEALTH FUND? YES ☐ NO ☐ FUND NAME: MEMBER NUMBER: PLACE ON CARD:

ARE YOU ELIGIBLE FOR CHILD DENTAL BENEFIT SCHEME? YES ☐ NO ☐ MEDICARE NUMBER: PLACE ON CARD:

I HAVE CONFIDENTIAL MEDICAL HISTORY I WISH TO DISCUSS WITH THE DENTIST RATHER THAN WRITE DOWN: YES ☐ NO ☐

DO YOU HOLD A DVA CARD? YES ☐ NO ☐ CARD TYPE: CARD NUMBER: PLACE ON CARD:

ARE YOU CURRENTLY BEING TREATED BY A DOCTOR / SPECIALIST?
YES ☐ NO ☐ DETAILS: _____

ARE YOU CURRENTLY TAKING ANY PRESCRIBED OR OVER THE COUNTER MEDICATIONS OR TABLETS?
YES ☐ NO ☐ DETAILS: _____

DO YOU REQUIRE ANTIBIOTIC COVER BEFORE DENTAL TREATMENT?
YES ☐ NO ☐ DETAILS: _____

HAVE YOU HAD ANY ABNORMAL REACTION TO GENERAL OR LOCAL ANESTHETIC?
YES ☐ NO ☐ DETAILS: _____

ARE YOU CURRENTLY (OR HAVE YOU EVER BEEN) A SMOKER?
YES ☐ NO ☐ DETAILS: _____

ARE YOU OR MAY YOU BE PREGNANT?
YES ☐ NO ☐ DETAILS: _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, DRUGS OR OTHER (INCLUDING LATEX)?
YES ☐ NO ☐ DETAILS: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS / TREATMENTS?

STEROID THERAPY	YES ☐ NO ☐	**EXCESSIVE BLEEDING**	YES ☐ NO ☐	**STOMACH / DIGESTIVE ISSUES**	YES ☐ NO ☐
RHEUMATIC FEVER	YES ☐ NO ☐	**BLOOD DISEASE / ANEMIA**	YES ☐ NO ☐	**HEPATITIS / LIVER DISEASE**	YES ☐ NO ☐
EPILEPSY	YES ☐ NO ☐	**LEUKEMIA**	YES ☐ NO ☐	**CONTACT WITH HIV / AIDS**	YES ☐ NO ☐
BRONCHITIS	YES ☐ NO ☐	**KIDNEY DISEASE**	YES ☐ NO ☐	**BISPHOSPHONATE THERAPY**	YES ☐ NO ☐
ASTHMA	YES ☐ NO ☐	**HEART VALVE ISSUES**	YES ☐ NO ☐	**ORGAN / MARROW TRANSPLANT**	YES ☐ NO ☐
LUNG DISEASE	YES ☐ NO ☐	**HEART MURMUR**	YES ☐ NO ☐	**DIABETIES TYPE 1 OR 2**	YES ☐ NO ☐
NERVOUS CONDITION	YES ☐ NO ☐	**HEART COMPLAINT**	YES ☐ NO ☐	**HIGH / LOW BLOOD PRESSURE**	YES ☐ NO ☐
RADIATION THERAPY	YES ☐ NO ☐	**STROKE**	YES ☐ NO ☐	**PROSTHETIC IMPANT**	YES ☐ NO ☐
CANCER	YES ☐ NO ☐	**CARDIAC PACEMAKER**	YES ☐ NO ☐	**THYROID DISEASE**	YES ☐ NO ☐

DENTAL ANXIETY SCALE (PLEASE CIRCLE):

HOW DID YOU HEAR ABOUT US?
GOOGLE FACEBOOK / INSTAGRAM RADIO / PRINT MEDIA
FRIEND / FAMILY (SPECIFY WHO): _____

SIGNATURE: PATIENT / PARENT / GUARDIAN _____ **DATE:** _____

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