DENTAL on errard

NEW PATIENT MEDICAL HISTORY FORM

Mr / Mrs / Ms / Mast / Miss/ Dr / Other:

First Name:_____

Surname:_____ **Person paying the account? Self / Other**

Date of Birth:_____ **Name**:_____ **Phone Number**:_____

Mobile Phone:_____ **Preferred Language**:_____

Email:_____ **Are you of Aboriginal or Torres Strait Islander decent? Yes / No**

Postal Address:_____ **Current Private Health Insurance for Dental? Yes / No**

Suburb:_____ **Postcode**:_____ **Name of Health fund**:_____

Parent / Guardian / Carer name: **Health Fund Number**:_____ **Ref number**:_____

_____ **Medicare Number**: _____ **Ref number**: _____

Emergency contact Name:_____ **Are you eligible for the Child Dental Benefits Schedule (CDBS)? Yes / No**

Contact Number:_____ **Veteran Affairs Card Number**:_____

Relationship to Emergency Contact:_____ **Is this a Workcover or Work related injury? Yes / No**

G.P name: _____ **Current Ambulance Insurance? Yes / No**

G.P Phone Number: _____ **Are you on Blood Thinners? Yes / No**

Ladies, Are you Pregnant? Yes / No How many weeks? _____

How Often do You Brush? **How Often Do You Floss:** **Have You ever had a Sleep Study? Yes / No**

HAVE YOU EVER HAD OR ARE YOU CURRENTLY SUFFERING FROM ANY OF THE FOLLOWING? PLEASE TICK IF YES

□ Angina	□ Anaemia	□ Other Chest Conditions	□ Digestive Condition
□ Heart Murmur/Disorder	□ Excessive Bleeding	□ Allergy to Latex	□ Epilepsy
□ Heart Surgery	□ Hepatitis A, B, C	□ Allergy to Penicillin	□ Fainting Disorder
□ High Blood Pressure	□ H. I. V	□ Other Allergies: _____	□ Kidney Disease
□ Low Blood Pressure	□ Other Blood Condition	□ Artificial Joint/s	□ Liver Disease
□ Pacemaker	□ Asthma	□ Back/Neck Pain	□ Psychiatric Condition (Eg. Anxiety)
□ Rheumatic Fever	□ Chest Surgery	□ Bone/Joint Disease	□ Radiation/Chemo Therapy
□ Stroke	□ Cystic Fibrosis	□ Cancer: _____	□ Sleep Apnoea
□ Thrombosis	□ Lung Disease	□ Dementia	□ Thyroid Disease
□ Other Heart Conditions	□ Pneumonia	□ Diabetes (Type 1 / Type 2)	□ Do you drink Alcohol Regularly
□ Have you travelled overseas recently? When did you return? _____			□ Do you smoke? How many daily? __

□ None of the above

PLEASE LIST THE MEDICATIONS YOU ARE TAKING BELOW. IF YOU HAVE A LONGER LIST PLEASE INFORM OUR STAFF

Name of Medication	Dose (eg. 10mg)	Reason for taking

HOW DID YOU HEAR ABOUT US OR WHO REFERRED YOU? **IF FRIEND WHO?**

□ I AGREE TO BE RESPONSIBLE FOR ALL PAYMENT AND I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE BY Cash / Cheque / Eftpos / Zip / Afterpay.

□ I UNDERSTAND IF I FAIL TO ATTEND ANY APPOINTMENTS, I WILL INCUR A $50.00 CANCELLATION FEE.

PATIENT SIGNATURE **PARENT/GUARDIAN SIGNATURE** **DATE**