PATIENT MEDICAL & DENTAL HISTORY FORM

dh denture health care
giving you the perfect smile

It is important to know about your medical/dental history as it could affect the success of the oral health care (dental treatment) provided. All of the information on this form will remain strictly confidential and will be handled in accordance with our privacy policy attached.

Last Name		First Names Mr/Mrs/Ms/Dr/other	
Date of Birth		Occupation	
Phone (Home)		Home Address	
Phone (Work)			
Phone (Mobile)			
Email			

(Please tick the box that you prefer we contact you on)

Dental Health Fund		Expiry Date	
Emergency Contact			

(Please provide contact address and phone number)

To be completed if the patient is under 18 years of age:

Guardian Name	

(Please provide contact address and phone number if different to above)

MEDICAL HISTORY

Name of your medical practitioner and phone number

Do you have confidential medical information that you do not wish to write down and would prefer to discuss with your dental prosthetist? **Please tick box →** ☐

Have you ever had any of the following? Please tick those that apply:

- ☐ Steroid therapy
- ☐ Rheumatic fever
- ☐ Epilepsy
- ☐ Heart Murmur
- ☐ Diabetes
- ☐ Heart valve disorder
- ☐ Stroke
- ☐ Psychological disorders
- ☐ Transplanted organ or marrow
- ☐ Kidney disease
- ☐ Excessive bleeding
- ☐ Heart complaint/disease
- ☐ Nervous condition
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ High or Low blood pressure
- ☐ Fainting/Dizziness
- ☐ Anaemia, leukaemia or other blood disease
- ☐ Prosthetic implant e.g. artificial hip
- ☐ Cardiac pacemaker
- ☐ Stomach or digestive condition
- ☐ Hepatitis or other liver diseases
- ☐ Contact with HIV/AIDS virus
- ☐ Anaphylactic reaction
- ☐ Cancer or radiation therapy
- ☐ Sinus problems
- ☐ Asthma, bronchitis, emphysema or other lung disease

	YES	NO	DETAILS
Are you being treated by a doctor at present?			
Have you had any serious illness in the past 2 years?			
Are you currently taking any medications or tablets?			
Do you Smoke?			

Please list any drugs or medicines your are allergic to (e.g. Penicillin):

Please list any known allergies (including latex, iodine etc.):

DENTURE HISTORY

Name of your Dentist?

When was your last dental exam?

Do you wear Full, Partial or no dentures?

How old are your current dentures?

Are you happy with the appearance of your current dentures?

Are your dentures ill-fitting?

Do you have difficulty in chewing your food?

Have you ever had injuries to your head, neck or jaw?

Do you suffer headaches or facial pain?

Do you have any pain or discomfort now?

Do your jaws click or pop when opening your mouth wide?

What is the main purpose of your visit today?

REFERRAL & PAYMENT INFORMATION

How did you find out about us?

How will you be paying your fee? **Please tick**

☐ Cash ☐ Eftpos ☐ Health Fund ☐ Credit Card ☐ Take Home Layby

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental procedures agreed to be necessary or advisable.
- I will assume responsibility for the fees associated with these procedures.
- I have read and accept the privacy policy attached.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment.
- We provide as a courtesy to our patients a denture recall program. Would you like us to contact you by:

☐ Mail ☐ Email ☐ Phone

Patient/Guardian Signature

Date

PRIVACY CONSENT POLICY

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Your Dental Prosthetist (DP) collects information from you for the primary purpose of providing quality dental health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your dental health care needs. This means we will use the information in the following way:

- Administrative purposed in running this Denture Clinic, including billing.
- Health Fund/Health Insurance Commission requirements.
- Disclosure to others involved in your dental health care, including treating doctors, dentists or other dental specialists outside this denture clinic practice.

This may occur through referral to a doctor, dentist or dental specialist.

The records of each consultation will be maintained and referred to by your DP in the management of any dental health problem that may arise.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this Denture Clinic has a privacy policy on handling personal patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so may comprise the quality of the dental health treatment and care given to me and potentially place myself at risk.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purposes other than as set out above, my further consent must be obtained.

I consent to the handling of my information by this Denture Clinic for the purpose set out above, subject to any limitations on access or disclose that I notify this Denture Clinic of.

I consent to being included on the recall database of the Denture Clinic, as detailed above.