PATIENT MEDICAL & DENTAL HISTORY FORM

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 handles in accordance with our privacy policy attached.

PERSONAL DETAILS

Surname		First Name		Preferred Name	
Date of Birth		Address			
Home Phone		Email			
Work Phone		Occupation			
Mobile		Referred By			
Medical Doctor					

MEDICAL HISTORY *Please indicate if you have or ever have had any of the following:*

- ☐ Yes ☐ No High Blood Pressure
- ☐ Yes ☐ No Heart problems, defects or pacemaker
- ☐ Yes ☐ No Rheumatic fever
- ☐ Yes ☐ No Asthma, chest or breathing problems
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Stomach or bowel problems or ulcers
- ☐ Yes ☐ No Kidney disease
- ☐ Yes ☐ No Anxiety or depression
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Thyroid problems
- ☐ Yes ☐ No Excessive bleeding or blood disorder
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Hepatitis (Hep B, Hep C, etc.)
- ☐ Yes ☐ No AIDS/HIV
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Any other contagious disease
- ☐ Yes ☐ No Do you have any heart valve, hip or other prosthetic implant?
- ☐ Yes ☐ No Do you have any allergies (e.g. penicillin or latex gloves?)
- ☐ Yes ☐ No Please list any medications you are presently taking:
- ☐ Yes ☐ No Is there any other medical condition that you wish to discuss in private?

DENTURE HISTORY

Name of Dentist		Last Dental Exam	
Do you wear Full, Partial or no dentures?		Age of Current Dentures	

- ☐ Yes ☐ No Are you happy with the appearance of your current dentures?
- ☐ Yes ☐ No Are your dentures ill-fitting?
- ☐ Yes ☐ No Do you have difficulty in chewing your food?
- ☐ Yes ☐ No Have you ever had injuries to your head, neck or jaw?
- ☐ Yes ☐ No Do you suffer headaches or facial pain?
- ☐ Yes ☐ No Do you have any pain or discomfort now?
- ☐ Yes ☐ No Do your jaws click or pop when opening your mouth wide?

Main purpose of visit today

How did you hear about us? ☐ Internet ☐ Word of Mouth ☐ Street Sign ☐ Referral ☐ Other

How will you be paying your fee? ☐ Cash ☐ Eftpos ☐ Health Fund ☐ Credit Card ☐ Payment Plan

Private Health Insurance		Membership No.		D.V.A. No.	
Signed		Date			

Please complete Privacy Consent on the other side of this form.

PRIVACY CONSENT POLICY

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

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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 ways:

- Administrative purposes 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 consultant 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 compromise 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 this Denture Clinic, as detailed above.

Signed		Date	

WATERFORD WEST
2/34 Loganlea Rd
Waterford West Q 4133

SUNNYBANK HILLS
Cnr Beenleigh Rd & Wynne St
Sunnybank Hills Q 4109

JINDALEE
5/132 Yallambee Rd
Jindalee Q 4074

REDBANK PLAINS
183 Kruger Pde
Redbank Plains Q 4301

BEAUDESERT
3/18 William St
Beaudesert Q 4285

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