PATIENT MEDICAL & DENTAL HISTORY FORM

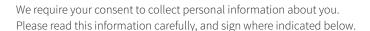
It is important to know about your medical/dental history as it could affect the success of the oral health care (dental treatment) provided. All of the information on this form will remain strictly confidential and will be handles in accordance with our privacy policy attached.



PERSONAL DETAILS

Surname	First Name			Preierred Name
Date of Birth	Address			
Home Phone	Email			
Work Phone	Occupation			
Mobile	Referred By			
Medical Doctor				
MEDICAL LUCTOR	NV or a straight of the straig	C 11 ·		
WEDICAL HISTOR	XY Please indicate if you have or ever have had any of the	following:		
Yes No	High Blood Pressure	Yes	No	Diabetes
Yes No	Heart problems, defects or pacemaker	Yes	No	Thyroid problems
Yes No	Rheumatic fever	Yes	No	Excessive bleeding or blood disorder
Yes No	Asthma, chest or breathing problems	Yes	No	Epilepsy
Yes No	Tuberculosis	Yes	No	Hepatitis (Hep B, Hep C, etc.)
Yes No	Stomach or bowel problems or ulcers	Yes	No	AIDS/HIV
Yes No	Kidney disease	Yes	No	Cancer
Yes No	Anxiety or depression	Yes	No	Any other contagious disease
Yes No	Do you have any heart valve, hip or other prosthetic impla	ant?		
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 disc	uss in private?	?	
DENTURE HISTO	RY			
Name of Dentist		Last De	ental E	xam
Do you wear Full, F	artial or no dentures?	Age of Curren	nt Dent	ures
Yes No	Are you happy with the appearance of your current de	ntures?		
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 w	vide?		
Main purpose of vis	sit today			
How did you hear a	about us? Internet Word of Mouth Stree	et Sign	Referra	al Other
now did you near a	about us: Internet word of Mouth Stree	er olğı i	кетегга	ou outer
		und Cro	edit Ca	rd Payment Plan
How will you be pa	aying your fee? Cash Eftpos Health Fu	illu Cle		
How will you be pa		_		D.V.A. No.
		_		

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 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	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





