

MEDICAL / DENTAL HISTORY FORM

Patient information

Mr. Mrs. Ms. Miss Master Other _____ Gender: _____ Date of Birth ____/____/____
 Surname _____ First Name _____ Preferred Name _____
 Address _____
 Suburb _____ Post Code _____
 Phone (M) _____ (H) _____ (W) _____
 Email Address _____

School	University	Occupation

Family Dentist Name or Dental Practice / Location: _____
 Do you have a letter of referral? **Not Needed** / **YES** (if yes) Dr _____
 Have you had X-Rays taken of your teeth? **NO** / **YES** (if yes, which company) _____
 Do you have a health fund? **NO** / **YES** if yes, please list here: _____
 How did you hear about us: **DENTIST** / **SCHOOL** / **WEBSITE** / **FAMILY** / **FRIEND**
 Other: _____

Account details (the person responsible for the account) (if as above, write AS ABOVE)

Mr. Mrs. Ms. Miss Other _____ Name _____
 Address _____
 Suburb _____ Postcode _____

Medical History

Any current illness/s? **NO** / **YES** if yes, list here: _____
 Any current medication/s? **NO** / **YES** if yes, list here: _____
 Any allergies? **NO** / **YES** if yes, list here: _____

Does the patient suffer from any of the following:

PLEASE TICK

Heart Disorder / Disease	NO <input type="checkbox"/> YES <input type="checkbox"/>	Major illness or disabilities?	NO <input type="checkbox"/> YES <input type="checkbox"/>
Heart Murmur	NO <input type="checkbox"/> YES <input type="checkbox"/>	Do you need antibiotic cover for dental treatment?	NO <input type="checkbox"/> YES <input type="checkbox"/>
High or Low Blood Pressure	NO <input type="checkbox"/> YES <input type="checkbox"/>	Speech or hearing difficulties?	NO <input type="checkbox"/> YES <input type="checkbox"/>
Rheumatic Fever	NO <input type="checkbox"/> YES <input type="checkbox"/>	Contact with HIV / AIDS virus	NO <input type="checkbox"/> YES <input type="checkbox"/>
Prolonged bleeding due to injury	NO <input type="checkbox"/> YES <input type="checkbox"/>	Asthma	NO <input type="checkbox"/> YES <input type="checkbox"/>
Diabetes	NO <input type="checkbox"/> YES <input type="checkbox"/>	Hepatitis	NO <input type="checkbox"/> YES <input type="checkbox"/>
Epilepsy	NO <input type="checkbox"/> YES <input type="checkbox"/>		

PLEASE TURN OVER 

We respect your privacy

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers the basic details such as your name, address and telephone number but it also necessary for the orthodontist to obtain from you details regarding your general health and past medical history or surgical events. Without this general health picture, the treating orthodontist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating practitioner in order to deliver your care to the highest standards
- It will not be disclosed to those not associated with your treatment, without your express consent
- You may seek access to the information held about you. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times
- There will be no charge made for requesting this information but there may be fees levied to cover the costs associated with the processing of the request of the copying of information
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date
- We will take reasonable steps to protect this information from misuse or loss and from unauthorized access, modification or disclosure
- Our staff are trained to respect these principles at all times

If you have any questions regarding the information we collect from you and hold in your records, please do not hesitate to ask us. We are acting in your interests at all times

I certify that the above information is correct and I have read and accepted the privacy policy. I will advise the orthodontist of any changes to the above information.

Signed _____ Date _____
(parent or guardian if under 18 years)