Patient History Form

Surname: Mrs. Miss. Ms. Mr. Master. ……

Other Names:…… Date Of Birth: ……

Home Address:…… Postcode: ……

Home Phone No: …… Mobile Phone No: ……

E- Mail: …… Person Responsible For Fees: ……

Do you have dental insurance? If yes, please provide details: ……

Business Address: …… Phone No: ……

Who is Your Medical Doctor? …… Phone No: ……

Nearest Relative (Not At Your Address): …… Phone No: ……

Did Someone Refer You to This Practice? If YES, who? ……

If NO, why did you select this practice? ……

Medical History

Please tick box if you have ever had, or suffer from any of the following:

Rheumatic Fever	☐	High Blood Pressure	☐	Diabetes	☐
Heart Ailments	☐	Excessive Bleeding	☐	Infectious Diseases	☐
Epilepsy	☐	Hepatitis	☐	Kidney Disease	☐
Asthma	☐	Prosthetic heart valve	☐	Prosthetic joints	☐

Are you a Smoker? (Please indicate how many per day) ……

Are you Pregnant? (Please indicate months) ……

Allergies to Drugs (Please indicate) ……

Other Serious Illnesses (eg cancer) ……

Are you currently receiving any Medical Attention? ……

Are you taking or receiving bisphosphonates?……

Taking other Medicine or Tablets (Please indicate) ……

Dental History

How long since your last dental visit? …… Are you nervous about treatment? ……

Have you had sore or bleeding gums when you brush? ……

Are you grinding or clenching your teeth? …… Have you had 'clicking' in the ear? ……

Have you had any pain in the face neck of back of head? ……

Signed: …… Date: ……

Privacy Statement

Health information is treated with utmost confidentiality in accordance with *Vic Health Records Act 2001* & *Privacy Act.* Disclosure will not be made to any person not involved in i) your treatment or ii) administration of this practice, without your prior written consent. If you have any queries please do not hesitate to raise the concerns with the practice.