HOLLAND PARK FAMILY DENTAL PRACTICE – Medical History Record

Thank you for selecting our practice to care for your dental health. Your current state of health, previous medical conditions, and any past surgery can have important influences on the dental treatment that we provide. As such, you are requested to complete this medical history record.

Personal Details

Title:

First Name: Middle Name:

Surname: Date of Birth:

Home Address:

Suburb: State: Postcode:

Home Ph: Mobile Ph: Work Ph:

Please indicate best contact number:

Email:

Occupation: Employer:

Work Address:

Suburb: State: Postcode:

Emergency Contact Name: Contact Ph:

Are you in a health fund? Yes☐ No☐ Name of Fund:

Who is responsible for Fees? Myself☐ Other (please name):

Medical History

Are you currently under the care of a medical practitioner? Yes☐ No☐

Name of Doctor: Contact Ph:

Do you take any **medications**? (prescription, over-the-counter, vitamin, or herbal) Yes☐ No☐

Please list:

Do you take 'blood thinning' (eg aspirin, warfarin, Plavix) medications? Yes☐ No☐

Do you take any osteoporosis (eg Fosamax, Actonel, Prolia injection) medications? Yes☐ No☐

Do you have **allergies** to: Penicillin☐ Sulphur☐ Latex☐ Codeine / Morphine☐ Aspirin☐

Other Allergies:

Have you ever had an adverse reaction to dental injections? Yes☐ No☐

Have you ever suffered excessive **bleeding** following a cut or dental extraction? Yes☐ No☐

Do you require **antibiotics** prior to dental treatment? Yes☐ No☐

Reason for antibiotics:

Are you a **smoker**? Yes☐ No☐ For Females, are you **pregnant**? Yes☐ No☐

Have you **ever** been diagnosed with any of the following conditions?

Rheumatic fever	Yes☐ No☐	Blood Pressure	High☐ Low☐ No☐
Heart / Blood Vessel Surgery	Yes☐ No☐	Heart valve replacement	Yes☐ No☐
Pacemaker Fitted	Yes☐ No☐	Heart Murmur	Yes☐ No☐
Angina	Yes☐ No☐	Heart Attack	Yes☐ No☐
Emphysema	Yes☐ No☐	Chronic Bronchitis	Yes☐ No☐
Asthma	Yes☐ No☐	Prosthetic Joint eg knee, hip	Yes☐ No☐
Arthritis Rheumatoid☐	Osteo-☐ No☐	Long-term steroid use	Yes☐ No☐
Stroke	Yes☐ No☐	Diabetes	Yes☐ No☐
Liver Disease	Yes☐ No☐	Kidney Disease	Yes☐ No☐
Epilepsy	Yes☐ No☐	Cancer	Yes☐ No☐
Radiotherapy	Yes☐ No☐	Thyroid Disease	Yes☐ No☐
Hepatitis	A☐ B☐ C☐ No☐	HIV	Yes☐ No☐

Please list other conditions:

Dental History

Name of Previous Dentist: Date of last check-up:

Purpose of today's visit:

Do you wish to discuss / obtain information regarding:

☐ Oral hygiene
☐ Fluoride Supplements for Children
☐ Tooth Whitening
☐ Cosmetic Procedures
☐ Crowns / Bridges
☐ Implants
☐ Other:

I herby consent to the collection, use and storage of this information as set out in the Privacy & Consent Statement and agree to the Practice Payment Policy below.

Patient / Parent / Guardian Name: **Date**:

How did you find out about us?

☐ Referral from family / friend: (Name)

- Yellow Pages: ☐ Locality Guide ☐ Dental Section ☐ Internet
- White Pages: ☐ Business Section ☐ Internet

☐ Signage ☐ Work in Neighbourhood

Other:

Practice Payment Policy

Our practice has HICAPS (health fund card claims), EFTPOS, & credit card facilities and we respectfully request that all services are **paid for in full on the day of treatment**. If you have any queries with this policy please discuss these with your dentist prior to commencing treatment.

Privacy & Consent Statement

We collect personal information from our patients in order to provide dental services. We are required by guidelines issued by the Australian Dental Association under the ***Health Practitioner Regulation National Law Act 2009*** to collect information from our patients and maintain dental records that contribute to the safety and continuity of your dental care. Please ask at reception for a copy of our full Privacy Policy Statement.

As a patient of our practice, you are taken to consent to us collecting, storing & using information that we collect from you as necessary for us to provide your dental health care, and in accordance with general industry practice. For example, you are taken to have given us general consent to disclose information about you to other dental practitioners, specialists & health care professionals where, in our opinion, this is beneficial to your overall dental health. Please keep us fully informed of matters affecting your dental or general state of health, whether temporary or more permanent nature. Failing to provide us with any relevant health information may have a detrimental affect on the level of dental care we are able to provide & could in extreme situations, put your dental or general health at serious risk.