

### PATIENT MEDICAL HISTORY

Title	MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> MASTER <input type="checkbox"/>		
Surname	First Name	DOB	/ /
Address			
State	Post Code		
Contacts	H:	M:	W:
Which method would you prefer to be contacted? H <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> SMS <input type="checkbox"/> EMAIL <input type="checkbox"/>			
Email:			
Would you like emails or SMS relating to Dental Care and Promotions? YES <input type="checkbox"/> / NO <input type="checkbox"/>			
Do you have private health insurance (Dental Cover) YES <input type="checkbox"/> / NO <input type="checkbox"/>			
Health Fund Eg: MBF	Number that you appear on card Eg: 1,2,3		
Medicare Number	____/____	Valid to	____/____
<i>Please note that bulk billing for dental treatment is not available at surgery. Medicare number is required in the event a scan requires radiographer to prepare report on scan done at surgery.</i>			
How did you hear about us?			
Friend/ Family/ Patient <input type="checkbox"/> , are they a patient of the surgery? If so please advise their name _____ – as we send a thank you voucher for referring you. Website/Google <input type="checkbox"/>			
Walk-in / Local <input type="checkbox"/> Yellow Pages <input type="checkbox"/>			
Dental Corporation <input type="checkbox"/> Corporate Program <input type="checkbox"/> Advertising <input type="checkbox"/> Other <input type="checkbox"/>			
Do you feel nervous about your dental treatment? (No) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Extremely) <i>please circle</i>			
When was your last dental check up? 3 - 6 months <input type="checkbox"/> 6 - 12 months <input type="checkbox"/> 12 - 18 months <input type="checkbox"/> 18 months + <input type="checkbox"/>			
<b>Allergies</b>	<b>Yes</b>	<b>No</b>	
Are you allergic to any: Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin <input type="checkbox"/> , Aspirin <input type="checkbox"/> , Nurofen <input type="checkbox"/> , Panadeine <input type="checkbox"/> , Other: _____
Medicines	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Foods	<input type="checkbox"/>	<input type="checkbox"/>	Dairy <input type="checkbox"/> , Nuts <input type="checkbox"/> , Other: _____
Metals	<input type="checkbox"/>	<input type="checkbox"/>	Nickel <input type="checkbox"/> , Mercury <input type="checkbox"/> Other: _____
Other	<input type="checkbox"/>	<input type="checkbox"/>	Latex <input type="checkbox"/> , Rubber <input type="checkbox"/> , Other: _____
Are you currently undergoing medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	If so, please advise.
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how many per day? _____ Since: _____
<i>Do you have any of the following symptoms:</i>			<b>Women Only</b> Are you, or suspect you may be pregnant? Yes <input type="checkbox"/> , if yes, your due date: _____ No <input type="checkbox"/>
Snoring?	<input type="checkbox"/>	<input type="checkbox"/>	
Reflux?	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension History?	<input type="checkbox"/>	<input type="checkbox"/>	
Excessively Tired?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a sleep study?	<input type="checkbox"/>	<input type="checkbox"/>	

Please tick box below if you have had, or have at present, any of the following				
Medical Condition(s)	Yes	No	Medication(s)	Year
Taking Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>		
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High <input type="checkbox"/> Low <input type="checkbox"/>	
Cortisone/Steroids	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Radiation treatment to head or neck area	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes I or Diabetes II	<input type="checkbox"/>	<input type="checkbox"/>	Type I <input type="checkbox"/> Type II <input type="checkbox"/>	
Have you had artificial joints? Eg: Hip, Knee, Elbow	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding Disorder Eg: Haemophilia	<input type="checkbox"/>	<input type="checkbox"/>		
Angina	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		
Prosthetic Valve	<input type="checkbox"/>	<input type="checkbox"/>		
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		
Stent	<input type="checkbox"/>	<input type="checkbox"/>		
Epilepsy When was your last attack? Known triggers	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma or Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	How severe? Mild <input type="checkbox"/> Severe <input type="checkbox"/>	
Hepatitis B/C	<input type="checkbox"/>	<input type="checkbox"/>		
HIV/ Aids	<input type="checkbox"/>	<input type="checkbox"/>		
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>		
Do you take any other medications?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have any other medical conditions?	<input type="checkbox"/>	<input type="checkbox"/>		

Payment Options	<p>EFTPOS <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> CASH <input type="checkbox"/> CHEQUES</p> <p>Please be aware that full payment is required at time of treatment – no accounts issued</p>
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Payment Plans	<p><b>GE Care Credit (Dental) ** Subject to approval**</b></p> <p>Interest free payment plan(s) (6,12,24 month payment plans available)</p> <p>Are you interested in this product? YES <input type="checkbox"/> / NO <input type="checkbox"/></p>
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<p><b>Cancellation Policy</b></p> <p>Please be aware that if you have an appointment/reserved chair time – failure to cancel your appointment 24 hrs prior to appointment or you fail to attend without notice – you may incur a cancellation fee of \$60.00 per half hour.</p>	
<p><b>Patient Signature</b></p> <p>X _____</p>	<p><b>Date</b></p> <p>_____</p>