Medical/Dental History Form

It is important to know your medical history so that we can provide treatment safely for you. Please provide full details regardless of how irrelevant they may seem. The information you provide is confidential and will be handled in accordance with our privacy policy which is shown on the reverse of this form.

Please complete in **CAPITAL LETTERS**.

Title:	**First name(s):**		**Last name:**
Date of birth:	**Occupation:**		
Home address:			
Postal address (if different):			
Home phone:	**Work phone:**	**Mob :**	**email:**
Name of emergency contact:			**Phone:**
Who is your medical practitioner?			
Do you have health insurance which includes dental cover? Yes ☐ No ☐ (Please tick)			**Name of fund:**
When did you last visit a dentist?		**Name of Dentist (if known):**	
How did you find out about *blue sky dental care*? (Please tick) **Patient or friend ☐ Yellow Pages ☐ Advertisement ☐ Road sign ☐ Other ☐ :**			

Please tick 'No' or 'Yes' as applicable	No	Yes	Details
Are you being treated by a doctor at present?			
Have you been hospitalized in the last 12 months?			
Are you taking any prescription or over-the-counter medications at present? Please list.			
Have you ever taken any medication for osteoporosis or other bone condition?			
Do you have a medical requirement for antibiotic cover before dental treatment?			
Have you had any unusual reactions to local or general anaesthesia?			
Do you have any allergies, eg penicillin, sulphur, latex, foods?			
Are you pregnant? (females only)			
Do you smoke?			
Do you use any type of dental appliance, eg mouthguard, denture?			

Please list any concerns which you may have with your teeth, gums or mouth:

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? Please tick either 'No' or 'Yes' for each condition								
	No	Yes		No	Yes		No	Yes
Heart disorder/ complaint			Diabetes: type 1 or 2 (please circle)			Thyroid disease		
Rheumatic fever/ heart murmur			Epilepsy			Bone or joint disease, including osteoporosis		
Cardiac pacemaker			Kidney disease			Prosthetic implant, eg hip, knee		
High or low blood pressure			Liver disease			Cancer		
Fainting/dizziness			Hepatitis A, B or C (please circle)			Radiation therapy		
Stroke			Anaemia or other blood disorders			Steroid therapy		
Asthma			Excessive bleeding			Stomach or digestive problem		
Bronchitis, emphysema, TB or other lung disease			Contact with HIV or AIDS			Nervous condition		
Any other conditions not included above (please list):								
I have confidential medical information that I do not wish to write down. I would prefer to speak directly to the dentist about this. ☐								

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

- *This information will only be used by your dentist in order to deliver care to the highest standards.*
- *It will not be disclosed to those not associated with your treatment without your consent except as provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information.*
- *You may seek access to the information held about you and we will provide this access without undue delay; 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 just to cover the costs associated with the processing of this request or the copying of information.*
- *We will take reasonable steps to ensure 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 unauthorised access, modification or disclosure.*
- *Our staff is trained to respect these principles at all times; please do not hesitate to ask any questions concerning the information collected.*

I declare that:

- **I have read and accept the privacy policy above and have accurately completed the Medical/Dental History Form**
- **I consent to the performing of dental surgery procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures**
- **I am aware that payment is required on the day of treatment and I agree to settle my account on that day**

Patient/guardian signature: …….. **Date: ……**	**Office use: ……..**