MUNDARING DENTAL CENTRE
Personal Information and Medical History Form

Title Mr / Mrs / Miss / Ms / Master / Dr		
Surname	First Name	D.O.B
Preferred Name	Postal address	Postcode
Email address		
Home No	Work No	Mobile
Health fund	Membership No	Patient ID on card
Medicare Card No Patient ID on card	Veterans' Affair Card No – Type of Card _____ Gold Card White Card	
Occupation		
Emergency contact name and number	Relationship to patient	

Person responsible for account. Must be completed if patient is under 16 (if same as above please tick here) ☐

Name _____ Relationship to patient _____

Phone (Mob) _____ (Hm) _____

DENTAL HISTORY

When was your last dental examination and clean? _____

Does dental treatment make you nervous? NO SLIGHTLY MODERATELY EXTREMELY

Are you happy with the appearance of your teeth and smile? YES / NO
Details_____

Are you concerned with any of the following?

☐ Hot / Cold Sensitivity	☐ Discoloured filling	☐ Clicking Jaw	☐ Cleaning Techniques
☐ Staining	☐ Bad breath	☐ Missing Teeth	☐ Existing Crowns
☐ Bleeding gums	☐ Grinding / Clenching	☐ Crooked Teeth	☐ Bridges / Dentures
☐ Head / Neck ache	☐ Amalgam Fillings	☐ Gaps between teeth	☐ Previous Treatment

Please tell us how you heard about us:

☐ Passing by / walked in	☐ Health Engine	☐ Family / Friend	☐ Preferred Provider
☐ Local newspaper	☐ Other_____	☐ Google (search term used) _____	

MEDICAL HISTORY

Are you currently receiving any medical treatment? Y ☐ N ☐
Details _____

Have you been hospitalised in the past 12 months? Y ☐ N ☐
Details _____

Please indicate if you have EVER had any of the following:

Heart complaint / treatment	Y / N	Asthma/ Bronchitis	Y / N
Tuberculosis	Y / N	Radiation therapy OR Chemotherapy	Y / N
Rheumatic fever or heart valve surgery	Y / N	Joint replacement Details:_____	Y / N
Any nervous system disorder	Y / N	Diabetes Verify type: _____	Y / N
High blood pressure	Y / N	HIV / AIDS	Y / N
Low blood pressure	Y / N	Treatment for cancer	Y / N
Anti – coagulant therapy	Y / N	Pacemaker	Y / N
Osteoporosis or low bone density	Y / N	Jaundice / liver disease	Y / N
Women: Are you pregnant If yes, due date: _____	Y / N	Do you smoke	Y / N

GP: Dr. _____ Phone _____

Please list ALL current medications (Prescription, over the counter and herbal)

_____

ALLERGIES ☐ Nil known ☐ Penicillin ☐ Latex ☐ Other _____

I agree that the above information provided is a true and accurate record.

I understand that failure to attend any appointments or cancellations without providing a minimum of 24 hours' notice may incur a cancellation fee of $75.00

I understand that Mundaring Dental centre requires payment on the day of treatment. Any expenses, costs or disbursements incurred by Mundaring Dental centre in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above.
I hereby consent to the use of any study models, x-rays, images and photographs at dental seminars, lectures and publications that the dentist / dental prosthetist may author.
I authorise the clinic to send sms, emails and correspondence to my email address provided.

PLEASE NOTE: This form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process.

Signature _____ Date ____ / ____ / _____