Office use only
Dentist _____
PT
Code_____

Bridge Rd Dental Medical History Questionnaire

Welcome to Bridge Rd Dental. In order to provide you with complete quality care we need to know about your state of health and medical history. In accordance with the Privacy Amendment Act 2000, and the Health Records and Information Privacy Act 2002, all information provided will be treated in strictest confidence and available only to third parties you have consented to. Please complete as accurately as possible. ***Thank you***

How did you hear about us?
_____

Patient information

Title Dr / Mr / Mrs / Miss / Ms

Surname _____ First name _____ Date of birth ____ / ____ / ____

Home address _____ Postcode _____

Postal address _____ Postcode _____

Phone (H) _____ (W) _____ (M) _____

Email_____

Occupation _____

Employer's name _____

Health fund for dental cover _____ Membership No _____ Series No. _____

Emergency contact _____ Relation to patient _____ Contact no. _____

Person responsible for account

Name _____ Relationship to patient _____

Address _____ Phone (H) _____ (W) _____

If third party, insurance company/employer responsible for account
_____

Contact name _____ Phone _____

Address _____ Postcode _____

Past/current medical conditions

Information about your medical history is for your dentists use only.

	No	Yes		No	Yes
Anaemia	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Intellectually Disabled	☐	☐
Artificial Joints	☐	☐	Irregular Heart Beat	☐	☐
Asthma	☐	☐	Kidney Disorder	☐	☐
Bleeding Disorder	☐	☐	Liver Disorder	☐	☐
Blood Transfusion	☐	☐	Lung Disorder	☐	☐
Cancer	☐	☐	Lupus	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐
Cholesterol	☐	☐	Physically Disabled	☐	☐
Diabetes	☐	☐	Radiotherapy	☐	☐
Endocarditis	☐	☐	Rheumatic Fever	☐	☐
Epilepsy	☐	☐	Smoker	☐	☐
Gastro Intestinal Disorder	☐	☐	Stomach Ulcer	☐	☐
Heart Attack/Angina	☐	☐	Stroke	☐	☐
Heart Bypass	☐	☐	Thyroid Disorder	☐	☐
Heart Murmur	☐	☐	Tuberculosis	☐	☐
Heart Valve Problem	☐	☐	Are you Pregnant?	☐	☐
Others	☐	☐	Specify _____		

Medical practitioner _____ Suburb _____
Last visit _____
Previous dentist _____
Last dental visit _____

Current medication
(Prescription, over the counter, herbal)

Allergies
☐ Nil known
☐ Yes - Details

Infectious history
☐ Nil known
☐ Yes - Details

Recent hospitalisation/surgery
☐ Nil known
☐ Yes - Details

Other relevant details
☐ Nil known
☐ Yes - Details

I agree that the above is a true and accurate record. I understand that this Bridge Rd Dental requires payment on the day of treatment. Any expenses, costs or Disbursements incurred by the Bridge Rd Dental in recovering any outstanding monies including debt collection fees and legal costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

PLEASE NOTE:
The medical history 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. This form is a guide only and you should discuss any relevant matters with your Dentist prior to the commencement of any dental treatments.

Signature _____ Date ___ / ___ / _____