Patient History Form

PERSONAL DETAILS

Last name: _____ Title: ◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Master ◯ Dr ◯ Other

First name: _____ Preferred name: _____

Date of birth: ____ / ____ / _____

Address: _____ Suburb: _____ Postcode: _____

Home Phone: _____Work: _____ Mobile: _____

Email: _____ Occupation: _____

Are you in a Private Health Fund? ◯ No ◯ **Yes- please list details below:**

Name of your health fund: _____ What is the number next to your name? e.g. 01, 02 etc ____

Preferred method for appointment confirmation: ◯ SMS ◯ Phone: H/W/MOB- Please circle

In case of emergency please provide emergency contact details: Name: _____

Relation to you _____ Phone: (H) _____ (Mob) _____ (W)_____

Is another member of your family a patient with us? _____

How did you find out about us?

◯ Internet search (**Please circle:** Google/ Yellow pages/ White pages/ Other) ◯ Walk/ Drive by ◯ Work in centre

◯ Yellow or White pages ◯ Recommended by: _____ ◯ Other:_____

MEDICAL HISTORY

Please provide details of the medical practitioner you attend most regularly:

GP Name: _____ Practice Name: _____

Phone number: _____

Are you taking any of the following **BISPHOSPHONATE** medications?
Please circle- Alendronate, Risedronate , Pamidronate, Zoledronic acid, Tiludronate, Etidronate, Clodronate, Fosamax, Actonel, Zometa, Aredia, Aclasta, Pamisol, Skelid, Didrocal, Bonefos, Dronalen, Denosumab, Prolia for injection, Other_____

Are you taking any of the following **BLOOD THINNING** medications?
Please circle - Aspirin, Warfarin, Plavix, Coumadin, Cartia, Marevan, Clopidogrel, Apixaban, Equilis, Rivaroxiban, Xarelto, Dabigatran, Pradaxa, Other_____

Please list **ALL** medications you are currently taking (**including over the counter and herbal medications)**:

_____

_____

Are you pregnant? ◯ No ◯ **Yes- due date?**_____ Do you have an **allergy** to Latex? ◯ No ◯ **Yes**

Do you have any **allergies or abnormal reactions** to drugs, food, anaesthetics or materials? ◯ No ◯ **Yes – please list:**

_____

HEART CONDITIONS- past & present (please tick & circle)	NO	**YES**		NO	**YES**
Congenital Heart Disease			Heart Murmer/ Valve Prolapse		
Artificial Heart Valve/ Stent			Heart Disease/ Heart Attack		
Rheumatic Fever/ Infective Endocarditis			Heart Pacemaker		
If **YES** to any of the above, have you ever been advised to have **Antibiotic Cover** prior to dental treatment?					

***** PLEASE TURN OVER *****

Have you had, or have at present any of the following? **(Please tick and circle appropriate condition)**

	NO	YES		NO	YES
High/ Low Blood Pressure			Frequent Headaches		
Stroke			Sinus Trouble/ Hay fever		
Chest Pain			Gastric Reflux/ Stomach Condition		
Excessive Bleeding/ Haemophilia			Dry Mouth/ Low saliva flow		
Thyroid Problems			Diabetes		
Asthma			Are you a smoker		
Bone disease, including osteoporosis			Chronic Cough		
Turberculosis			Transplant		
Glaucoma			CJD (Creutzfeldt Jakobs Disease)		
Arthritis/ Rheumatism			Kidney Disease		
Bronchitis, Emphysema or other lung diseases			Nervous Disease / Psychiatric Disorder		
Anaemia, leukaemia or other blood diseases			Steroid or Cortisone Treatment		
Hepatitis A B C / Other Liver Disease			Fainting/ Dizzy Spells		
Contact with blood borne viruses or HIV/ AIDS			Epilepsy		

Cancer (Radiation/ Chemotherapy)		- Please provide details:
Artificial Joints (eg. Hip, Knee)		- When was it placed?
Any other conditions?		- Please provide details:
Are you currently undergoing any medical treatment?		- Please provide details:

DENTAL HISTORY

What is the purpose of your visit today? _____

How long has it been since your last dental visit? _____ months _____ years

Why did you leave your previous dental practice? _____

Is there something particular you would like information on today?

◯ Oral hygiene ◯ Replacing a missing tooth ◯ Teeth Whitening ◯ Cosmetic ◯ Other:_____

What type of toothbrush do you use? ◯ Manual ◯ Electric Brush

Do you use interdental products (eg floss or piksters) regularly? ◯ No ◯ Yes

Do you play a contact sport? ◯ No ◯ Yes- If yes, do you have a custom made Mouthguard? ◯ No ◯ Yes

Are you aware or has someone told you that you grind your teeth? ◯ No ◯ Yes

Do you wear a splint/night guard? ◯ No ◯ Yes

I accept responsibility for payment of the account at the time of treatment.
For your convenience we accept cash or cheque and have EFTPOS facilities and immediate health refund facilities.

SIGNATURE : _____ DATE: ____ / ____ / ____ STAFF Initials_____

Privacy Statement: In order to provide you with the highest standard of care, Cannon Hill Dental needs to collect personal information and details from you. Please be assured that the information is confidential and used only for the purpose of providing treatment to you. If you have any questions regarding this information or would like to talk directly to the dentist regarding your medical history please do not hesitate to ask one of our friendly staff members for assistance.

MEDICAL HISTORY UPDATE

Date Updated			
Signature			
Staff initial			