



Bridge Rd Dental Medical History Questionnaire

Office use only
Dentist _____
PT _____
Code _____

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 <small>Information about your medical history is for your dentists use only.</small>				Current medication <small>(Prescription, over the counter, herbal)</small>			
	No	Yes		No	Yes	Allergies <input type="checkbox"/> Nil known <input type="checkbox"/> Yes - Details	
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Infectious history <input type="checkbox"/> Nil known <input type="checkbox"/> Yes - Details	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Intellectually Disabled	<input type="checkbox"/>	<input type="checkbox"/>	Recent hospitalisation/surgery <input type="checkbox"/> Nil known <input type="checkbox"/> Yes - Details	
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Other relevant details <input type="checkbox"/> Nil known <input type="checkbox"/> Yes - Details	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>		
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Physically Disabled	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>		
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	<input type="checkbox"/>		
Gastro Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Bypass	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Valve Problem	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		
Others	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____	<input type="checkbox"/>	<input type="checkbox"/>		
Medical practitioner _____ Suburb _____ Last visit _____ Previous dentist _____ Last dental visit _____							

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 ____ / ____ / ____