VICTORIA

PATIENT HISTORY SHEET

Health Information is gathered for treatment purposes only. This information enables the provision of optimal dental care and helps in avoiding compromise of the patient's general medical health.
Note: So that this dental practice can provide the highest standard of care, please fill in this form carefully and thoroughly.

Surname: ..... Title: (e.g. Mr/Mrs/Ms/other) .....

Other Names: ..... Date of Birth: .....

Home Address: ..... Business Address: .....

.....P/Code: ....P/Code: .....

Ph: .....Mobile: .....(BH) Ph: .....Fax: .....

Email: .....

Postal Address (if different to above): .....

Name of Person responsible for Fees: .....

Address (if different to above): .....

Emergency Contact: ..... Relationship .....

Address: .....P/Code: .....Ph: .....

Medical Doctor: .....

Address: .....P/Code: .....Ph: .....

Who recommended this practice to you? .....

NOTICE TO INSURED PATIENTS REGARDING DENTAL BENEFITS INSURANCE

Item numbers on our statement represent as accurately as possible the procedures performed, but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures, to attract refunds, and the rates of those refunds, are determined by the conditions of the patient's Health Insurance Policy. We accept no responsibility, to either party, for any decision the Insurer may make regarding the refund of monies to the patient.

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE:

	YES	NO		YES	NO
High blood pressure	☐	☐	Diabetes	☐	☐
Heart ailment	☐	☐	Thyroid problems	☐	☐
Rheumatic fever	☐	☐	Excessive bleeding or blood disorder	☐	☐
Asthma, chest or breathing problems	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
Stomach or bowel problems (eg ulcer)	☐	☐	AIDS/HIV	☐	☐
Kidney disease	☐	☐	Bone Disorders or Diseases	☐	☐

Do you smoke? Yes ☐ No ☐ How many? _____/day Would you like to stop? Yes ☐ No ☐

List any other previous illnesses: .....

Would you like to discuss these questions in private with the dentist?	☐	☐
Do you have: an artificial hip, heart valve or other prosthetic implant?	☐	☐
Have you ever had problems with dental treatment?	☐	☐
Are you presently under medical care?	☐	☐
Are you taking any drugs, medicines or tablets? (Please list)	☐	☐
Female patients, are you pregnant?	☐	☐
Do you have allergies?	☐	☐

List any medicines or products you are allergic to (e.g. Penicillin, Latex): .....

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

Signed.....Date: .....

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED.
WORKING FOR THE COMMUNITY'S DENTAL HEALTH