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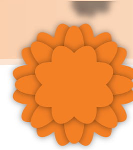

dentalexcellence

Patient Medical History Form

WE RESPECT YOUR PRIVACY

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number, but it is also necessary for us to obtain from you details regarding your general health and past medical or surgical treatments and procedures. Without this general health profile, the treating Dentist or Hygienist is unable to plan your care properly.

Naturally, some of this information is of a personal nature, some of it may be regarded as 'sensitive' and not the sort of information you would wish to be unnecessarily disclosed to others. Our practice is equipped with CCTV security cameras always visible and in discreet areas such as the waiting room, treatment rooms and the sterilisation area. Our monitored system is installed to keep the safety of our patients and staff in check when and if required. You can rest assured that our system records and saves video footage only for a few days and records it over itself again. This assists us in ensuring safe delivery of treatment services are being carried out at all times as well as for our staff's safety and peace of mind. If you are concerned in any way, please don't hesitate to contact us. We value the need to safeguard this information and in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating Dentist or Hygienist in order to deliver your care to the highest standards
- It will not be disclosed to those not associated with your treatment without your expressed consent
- You may seek access to the information held about you and we provide this access within 2-3 days of a written request received. This access might be by inspection of your dental records at the time of your appointment or by special access or copying of information at other times by completing a records release request form.
- We will not send clinical information about patients via email unless it is by email to secure domain email addresses and not gmail, yahoo, hotmail or other free emails.
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date
- We will take all reasonable steps to protect the privacy of our patients' information from misuse or loss and from unauthorised access, modification or disclosure
- Our staff are trained to respect these principles at all times

If you have any questions regarding the information we collect from you and hold in your dental records, please do not hesitate to ask us. We are acting in your interest at all times.

Please Circle: Dr Mr Mst Mrs Ms Miss

First Name .... Surname ....

Address No .... Street Name .... Suburb .... P/Code ....

Home phone .... Work phone .... Mobile phone ....

Email Address ....

Date of birth .... Occupation ....

Health insurance .... Ref No .... Member No ....

Contact person in case of emergency .... Ph. .... Relation to you ....

Who referred you to our practice? ....

When was your last dental visit? ....

Why did you leave your last dentist? ....

What has been your concern with previous dental visits ……………………………………………………………………………

What is your main dental concern today? ……………………………………………………………………………

Are your teeth sensitive to:

Hot Cold Biting pressure Sweet

Does food catch between your teeth? ……………………………………………………………………………

Do your gums bleed when brushing or flossing? ……………………………………………………………………………

Do you notice an unpleasant taste or odour in your mouth? ……………………………………………………………

Have you had any complications during or following dental treatment? …………………………………………………

Have you had prolonged bleeding after tooth removal or dental surgery? ………………………………………………

Is there anything you would like to change about your teeth/gums or their appearance? ……………………………

Do you grind your teeth or clench your jaws? ……………………………………………………………………………

Have your jaw muscles ever been sore? ……………………………………………………………………………

Please describe how you feel about dental treatment by putting an X on this line

PLEASANT ……………………………………………… X ……………………………………………………………TERRIBLE

Do you smoke? Yes No How many per day? ………… How long have you smoked? ………………

Are you being treated for a medical condition?

Who are your doctors/GP / GP Clinic/ Specialist? ……………………………………………………… Ph ……………………

We may request access to medical history or medications for some dental treatments

For Females, Are you pregnant? YES NO If Yes, What is your due date: ……………………………………

Are you breast feeding? YES NO

Are you taking Contraceptives? YES – Name: …………………… NO

Have you ever been hospitalized or had a major operation? YES NO If Yes, When: ………………

If yes, please give details

………

Average alcohol intake per week? ……………………………………………………………………………

What is your current body weight? ……………… KG

Do you take any of the following medications/supplements or treatments?

Chemo/ Radiation Therapy	Thyroxin	Herbal/ Natural Meds
Asthma Inhalers	Anxiety Medications	Cholesterol Meds
Anti-depressants	Bisphosphates	Blood Thinners
Blood Thinners – Warfarin or Aspirin	Prolia Injection	Steroid Tablets

Please list all names of medications with dosage and frequency

………

Do you have any allergies or sensitivity to any of the following and describe the reactions:

Antibiotics	Latex	Lactose/ Milk products
Bandages	Codeine	Various Foods
Penicillin	Sulphur Drugs	

OTHER- Please specify: ……

Are you taking any other medications or supplements at present, both prescribed or over the counter?
(Please list with correct dosage & frequency)

………

Do you have, or have you ever had, any of the following medical conditions?

Steroid therapy	Leukemia, cancers	HIV/AIDS
Rheumatic fever	Nervous condition	Anemia or blood disorder
Epilepsy	Tuberculosis	Prosthetic implant eg. Prosthetic hip or knee
Asthma	Heart murmur	Bronchitis, emphysema or other
Diabetes	High blood pressure Current reading ………………	Lung disease
Heart valve disorder	Low blood pressure Current reading ………………	Osteoporosis
Stroke	Organ or bone marrow transplant	Thyroid disease
Radiation or chemotherapy	Pacemaker	Hypothyroidism
Kidney problems	Bleeding problems	Hyperthyroidism
Heart complaint or heart surgery	Hepatitis or liver disease	Other
Eating disorder		………………………………………
Stomach or digestive condition (reflux)		

We like to see you smile with confidence and get the most out of your visits. Please tick the dental care options you'd like to know more about or would consider in the future:

Gum Therapy/ rejuvenation (PST)	Fresher Breath	Dry mouth	Teeth Whitening
Tooth Coloured Fillings	Children's Dentistry	Cosmetic Tooth Alignment	Missing teeth options
			Oral Health Tips

Dental Excellence from time to time offers in-house specials, gift vouchers, products, promotions and information seminars.

Would you be interested in receiving an invitation? YES NO

if Yes, would you prefer: SMS EMAIL LETTER

To protect your privacy do you give consent for a third party or family member access to your records?

YES NO

If yes, I give consent for:

Full name of third party or family member: ……………………………………………………………………………

Contact details: …….

Relationship: ……..………………………………………………………………………………………………………..

to:

Update records

Make changes to appointments

Request records

Make enquiries on your behalf

Please read and tick each section:

To the best of my knowledge, the questions above have been accurately answered. I understand the importance of providing both accurate and updated information to Dental Excellence.

I understand 24 hours notice is required for cancellations or changes to my appointment, as fees may apply.

I CONSENT the use of my dental diagnostic models, x-rays, before & after pictures for educational and/ or advertising purposes. No identity will be disclosed.

I understand CCTV is used in the practice for the safety of patients & staff as well as for staff training and development purposes

I understand that major treatment requires a 20% deposit of the total cost to book a date and 50% of the major treatment cost may be requested 3-5days prior, or as advised by Dental Excellence.

I am responsible for FULL PAYMENT of all my accounts UNLESS PRIOR APPROVAL obtained from the practice. Any collection fees incurred is my responsibility. I understand my responsibility to inform Dental Excellence of any changes to my medical status, health fund and contact details.

I would like to be part of the Dental Excellence VIP club and receive a Facebook/ Twitter/ Instagram request.

Signature: ____ Date: ________________________