Passion Family Dental
North Lakes

MEDICAL HISTORY FORM

Welcome to Passion Family Dental North Lakes

Thank you for allowing us to take care of your dental health. The information supplied in this form will guide us in supplying a high standard of care designed especially for you, so please complete this form as accurately as possible. Please advise us if any of these details change, all information will be treated with complete professional confidentiality.

Title: Mr / Mrs / Ms / Miss / Master / Other

Surname: _____ First name: _____

Preferred name (if different to above): _____

Date of birth: _____/_____/_____

Address: _____

Suburb: _____ Postcode: _____

Phone: (Mob) _____ (Hm) _____ (Wk) _____

Email: _____

Do you have Private Health Insurance for dental cover? ☐ Y / ☐ N _____

Name of Health Insurance Fund: _____

Private Health Insurance Membership No: _____Patient ID: _____

Are you a Veteran Affairs Gold Card holder? ☐ Y/ ☐ N _____ (Card No.)

Occupation: _____

Emergency Contact: _____ Relationship: _____Contact No: _____

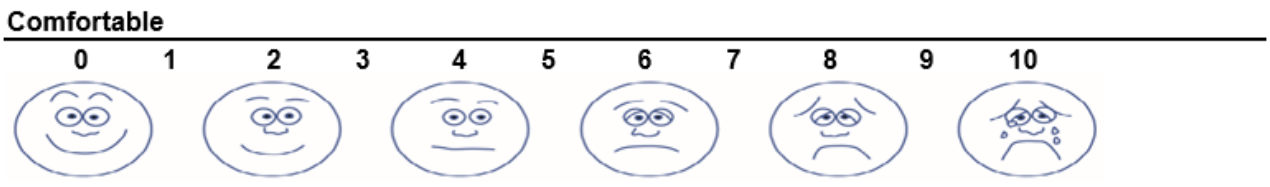
How did you hear about Passion Family Dental?

☐ Google Search ☐ Facebook ☐ Walk-By/ Drive Past ☐ Insurance Plan

☐ Word of Mouth/Referral: _____ (please write referrers name as we like to send a thank you voucher)

☐ Flyers ☐ Other: _____

We provide a very gentle treatment, but we want to know how much you fear dentists on a scale of 0-10



Medical Questionnaire-Private and Confidential

Do you require Antibiotic Cover before dental treatment? Y ☐ N ☐
(for Heart Valve disorder or Prosthetic Joints etc)

Allergies Nil known ☐ Yes ☐ Details: _____

Past/ Current medical conditions:

Are you receiving any medical treatment at present Y ☐ N ☐ Details: _____

Have you had any serious or long standing illness Y ☐ N ☐ Details: _____

Have you ever been hospitalised Y ☐ N ☐ Details: _____

Please indicate if you have EVER had any of the following:

Any heart complaint/ treatment	Y ☐	N ☐	Tuberculosis	Y ☐	N ☐
Rheumatic fever of heart valve surgery	Y ☐	N ☐	Any nervous system disorder	Y ☐	N ☐
High or low blood pressure	Y ☐	N ☐	Gastric ulcer	Y ☐	N ☐
Blood disorders	Y ☐	N ☐	Asthma/ Breathing problem	Y ☐	N ☐
Anti-coagulant therapy	Y ☐	N ☐	Thyroid disease	Y ☐	N ☐
Osteoporosis or low bone density	Y ☐	N ☐	Hepatitis or liver disease	Y ☐	N ☐
Epilepsy	Y ☐	N ☐	Organ transplant	Y ☐	N ☐
HIV	Y ☐	N ☐	Cancer	Y ☐	N ☐
Radiation Therapy/ chemotherapy	Y ☐	N ☐	Kidney disease	Y ☐	N ☐
Anxiety/ Depression	Y ☐	N ☐	Cardiac Pacemaker	Y ☐	N ☐
Prosthetic heart valve	Y ☐	N ☐	Thyroid disease	Y ☐	N ☐
Anaemia	Y ☐	N ☐	Sinus problem	Y ☐	N ☐
Do you smoke	Y ☐	N ☐	Pregnant (when due)_____	Y ☐	N ☐

Other _____

Current medications (prescription, over the counter, herbal) _____

_____

Medical Practitioner Name: _____Suburb: _____Phone: _____

How long since your last dental appointment? _____

I agree that the above is a true and accurate record. I understand that payment on the day of treatment is required. I have read and agree with the privacy statement on the back of this document. I further agree for Passion Family Dental to contact me via electronic communication.

Parent or Guardians signature required if patient is under the age of 18 years.

Signature: _____ Date_____

Name: _____

IMPORTANT - PLEASE READ PRIVACY STATEMENT INCLUDED IN THIS FOLDER