Passion Family Dental
North Lakes

MEDICAL HISTORY FORM

Current Temperature:

_____

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.

Has anyone been in direct contact with someone who has been *confirmed or under investigation* as having Covid-19, or in quarantine?	Yes	No
Have you **travelled interstate, contact tracing exposure sites or to any hot spots** in the past **14 days**?	Yes, Where? _____	No
How are you feeling? (No fever, sore throat, loss of taste, tiredness etc.?)	Well	Unwell

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

First name: _____ Surname: _____

Preferred name: _____ Date of birth: _____/_____/_____

Occupation: _____ Telephone (Mob/Hm/Wk): _____

Address: _____

Suburb: _____ Postcode: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Telephone: _____

Your Medical Centre: _____ Practitioner Name:_____

Phone: _____

Do you have Private Health Insurance for dental cover? ☐ Y / ☐ N (Name): _____

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

Do you have Metro North Dental Voucher? ☐ Y / ☐ N (Voucher No): _____

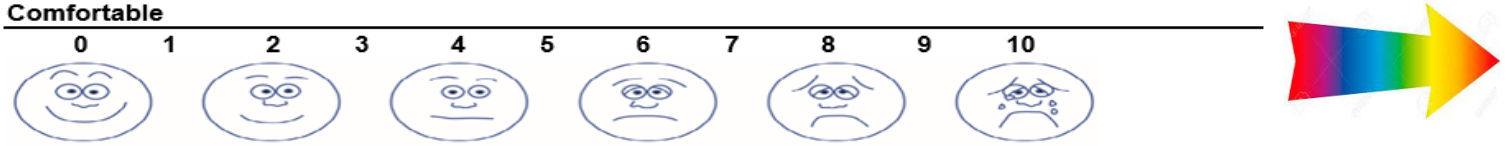
Are you eligible for Children Dental Benefit Scheme? ☐ Y / ☐ N (Medicare No):_____

How did you hear about Passion Family Dental?

☐ Google ☐ Facebook ☐ Walk-By/ Drive Past ☐ Health Fund / Metro North

☐ Family/Friend ☐ Website Ad ☐ Instagram ☐ Your Medical Practitioner

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



Dental & Medical Questionnaire - Private and Confidential

How long since your last dental exam and clean? _____

Which oral health condition do you want? (Tick if apply)

☐Healthier Teeth ☐ Whiter Smile ☐ Stronger Teeth ☐ Replace Missing Teeth

☐Others: _____

Past/ Current medical conditions:

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

Allergies: Nil known ☐ Yes ☐ Details: _____

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 ☐	Anxiety/ Depression	Y ☐	N ☐
HIV	Y ☐	N ☐	Liver disease	Y ☐	N ☐
Rheumatic fever	Y ☐	N ☐	Hepatitis	Y - A ☐ B ☐ C ☐	N ☐
Acid reflux	Y ☐	N ☐	Asthma/ Breathing problem	Y ☐	N ☐
Blood pressure problem	Y - High ☐ Low ☐	N ☐	Sinus problem	Y ☐	N ☐
Anaemia	Y ☐	N ☐	Thyroid disease	Y ☐	N ☐
Diabetes	Y- Type 1 ☐ 2 ☐	N ☐	Cancer (type) _____	Y ☐	N ☐
Bone Disease	Y ☐	N ☐	Smoking _____/ Day	Y ☐	N ☐

Other: _____Pregnant N ☐ Y ☐ (when due) _____

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

_____

I agree that the above is a true and accurate record, I will advise my dentist of any changes to my medical history in the future. I understand that all medical details will be treated with complete professional confidentiality. I have read and agree with the privacy statement. I understand that payment on the day of treatment is required. I further agree for Passion Family Dental to contact me via electronic communication.

Patient Signature: _____ Date_____

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

IMPORTANT - PLEASE READ PRIVACY STATEMENT INCLUDED IN THIS FOLDER