ORAL HEALTH & BEYOND COLLECTIVE | KIDS healthy kids nurtured by nature | DentalCareXtra ~ your smile oasis | SNORING LASER CARE

Patient Medical History

PLEASE NOTE: This is an editable PDF. You are able to type in or select your answers to the questions.When you have completed the form, save this document to your own files. Our Team Member will request this form from you when required.

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy and consent for treatment which is included at the end of this form.

Last Name: ____
First Name: ____
Birthdate: ____
Name of Medical Doctor: ____
City/State: ____
Emergency Contact Name: ____
Phone: ____
Relationship: ____

Is a doctor treating you at present? ____
Are you taking any prescription or other medications at present? ____________________
____
Are you allergic to any food? Please list ____
____
Have you been hospitalised in the last 12 months? ___________________________________
Have you had any abnormal reactions to local or general anaesthesia? ________________
Tobacco use? If so, what kind and how much? ______________________________________
Are you pregnant? ____
Do you normally require antibiotic cover before dental treatment? ____________________
Is your diet high in sugar/high sugar frequency? ____________________________________
How many units of alcohol do you consumer per week? _______________________________
Do you use recreational drugs? ____
Do you drink a lot of fizzy or acidic drinks? _______________________________________

Warnings

	Y	N
Do you have a problem with being reclined?	☐	☐
Have you had steroids in the last 2 years?		
Do you have bruising or persistent bleeding after surgery or tooth extraction?		
Do you carry a warning card?		
Are you currently having treatment from a doctor, hospital of clinic?	☐	☐
Have you ever had treatment that required you to be hospitalised?	☐	☐
Is there anything else your dentist should know?	☐	☐

____
____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anaesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Heart disorder/surgery	☐	☐	Cancer
☐	☐	Hepatitis or other liver diseases	☐	☐	Blood transfusion/condition
☐	☐	Asthma	☐	☐	Kidney disease
☐	☐	Bleeding problems	☐	☐	Liver disease
☐	☐	Radiation/Chemotherapy	☐	☐	Thyroid disease
☐	☐	Diabetes	☐	☐	Nervous or psychiatric conditions
☐	☐	Heart murmur	☐	☐	Sinus trouble
☐	☐	Heart trouble	☐	☐	Stroke
☐	☐	High blood pressure	☐	☐	Ulcers
☐	☐	Bone, joint disease or Osteoporosis	☐	☐	Rheumatic fever
☐	☐	Fainting/blackouts/giddiness	☐	☐	Prosthetic implant e.g. artificial hip
☐	☐	Steroid therapy	☐	☐	Stomach or digestive condition
☐	☐	Anaemia	☐	☐	Pacemaker fitted
☐	☐	Sickle Cell	☐	☐	Low blood pressure
☐	☐	Angina	☐	☐	Organ transplant
☐	☐	Epilepsy	☐	☐	Hiatus hernia
☐	☐	Haemophilia	☐	☐	HIV
☐	☐	Acid reflux	☐	☐	Eating disorder
☐	☐	Bronchitis, Emphysema, Cystic Fibrosis, Pneumonia, or other chest conditions or lung diseases	☐	☐	Other illness ________________ ________________

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- COLLECTIVE -

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SNORING
LASER CARE

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 the dentist to obtain from you details regarding your general health and past medical or surgical events. Without this general health picture, the treating dentist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others.

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 in order to deliver your care to the highest standards.

It will not be disclosed to those not associated with your treatment without your consent except as provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information.

You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times.

There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.

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 reasonable steps to protect this information from misuse or loss and from unauthorised access, modification of 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 interests at all times.

Consent for Treatment

I hereby authorise the dentist or designated team member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of services unless other arrangements have been made. I understand that I will also be liable for any costs associated with the collection of any outstanding monies. I have read and accept the privacy policy as listed above.

Signature ________________________________ Date

Y N
☐ ☐ I do consent for use of my pictures for education and advertising
☐ ☐ I do agree to receive information and promotional materials by email