KEILOR DENTAL GROUP

# Patient History Sheet

In order for this dental practice to provide the highest standard of care, it is requested you fill in this form carefully and thoroughly.

First Name: ..... Surname: .....

Title: (Mr/Mrs/Ms/Miss/other) ..... Date of Birth: .....

Home Address: ..... P/Code: .....

Business Address: ..... P/Code: .....

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

Email: ..... Fax: .....

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

Emergency Contact: ..... Ph: .....

Relationship: ..... Address: ..... P/Code: .....

Medical Doctor: .....

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

Do you have dental insurance? Yes ☐ No ☐ If yes, which fund? .....

## Please TICK if you have / had any of the following:

- ☐ High Blood Pressure
- ☐ Heart Ailment
- ☐ Excessive Bleeding or Blood Disorder
- ☐ Asthma, Chest or Breathing Problems
- ☐ Tuberculosis
- ☐ Stomach or Bowel Problems (e.g. ulcer)
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Hepatitis A, B, C
- ☐ AIDS/HIV
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Artificial Hip, Knee, Ankle
- ☐ Arthritis

Please LIST all medications or drugs you are currently taking: .....

Please LIST any <u>other</u> operations/medical conditions/disabilities: .....

Please LIST any allergies to medication or substances: (e.g. latex) .....

Do you or have you ever taken Biophosphonate medications for any bones disorders? (e.g. Forsamax, Zometa) Yes ☐ No ☐

Have you ever had treatment for cancer including radiotherapy in the head/neck region? Yes ☐ No ☐

Have you ever been, or currently on Methadone &/or other withdrawal programs? Yes ☐ No ☐

**Female Patients:** Are you pregnant or do you think you may be pregnant? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ If yes, How many? _____ per/day.

How did you hear about this clinic? (Tick all that apply)

☐ Seen the practice ☐ Advertising ☐ Local Paper ☐ Yellow Pages Ad ☐ Internet Search Engine (i.e. Google, Bing, etc)

☐ Recommended by someone: ..... ☐ Other, please specify: .....

**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, 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 patient.

**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 permission for the practice to use the above contact details to send me appointment and checkup reminders.**

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

**Guardian's Name** (if applicable)**:** .....

**ANY CHANGES TO THE ABOVE SHOULD BE ADVISED AT FUTURE VISITS**