BANKSIA HOUSE DENTAL SURGERY - MEDICAL / DENTAL HISTORY FORM

In order to give you the best possible care, it is important to know details about your medical history as these could affect the success of your dental treatment. The information you provide is confidential, and will be handled in accordance with our privacy policy.

First Name_____ Preferred Name_____ Last Name_____

Date of Birth ____/____/____ Occupation _____Email_____

Home Address_____Post Code_____

Postal Address_____Post Code_____

Phone: H_____W_____M_____

Spouse/Partner/Parent: Name_____ Phone _____

Emergency Contact (if other than above): Name_____ Phone_____

Do you have any special needs we need to be aware of? _____

Are you able to provide consent for dental treatment (must be over 18)? YES / NO – if NO please complete next question

Consent provider/Medical Power of Attorney: Name_____Phone_____

Can you claim dental expenses through a private health fund? If Yes, which one?_____

I have confidential medical information I would prefer to speak to the dentist about privately. Please circle one YES / NO

Are you under ongoing care by a doctor? YES / NO Details_____

Are you taking any medicines (prescription or over-the-counter) at present? YES / NO If yes, please complete list over page.

Do you normally require Antibiotic cover before dental treatment? YES / NO Details_____

Have you had any abnormal reactions to local or general anaesthetics? YES / NO Details_____

Do you smoke? (If Yes, how many per day?) YES / NO How many?_____

Are you pregnant /breastfeeding? YES / NO How many weeks pregnant?_____

Who is your Doctor? _____Surgery_____ Phone_____

List all known allergies / adverse drug reactions (inc Latex)_____

DO YOU NOW HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS / PROCEDURES? Please give details.

Heart condition_____	YES / NO	Kidney disease _____	YES / NO
Cardiac Pacemaker _____	YES / NO	Nervous conditions_____	YES / NO
Prosthetic implant eg. Hip _____	YES / NO	Thyroid disease_____	YES / NO
Rheumatic Fever _____	YES / NO	High or Low Blood Pressure_____	YES / NO
Bisphosphonate therapy for Osteoporosis_____	YES / NO	Transplanted Organ or Marrow_____	YES / NO
Radiation therapy _____	YES / NO	Stomach or digestive conditions _____	YES / NO
Excessive bleeding _____	YES / NO	Eating disorders_____	YES / NO
Steroid therapy _____	YES / NO	Hepatitis or other liver diseases_____	YES / NO
Epilepsy _____	YES / NO	HIV / Aids _____	YES / NO
Arthritis or back pain _____	YES / NO	Asthma, Emphysema or other lung diseases_____	YES / NO
Diabetes (if Yes what type?)_____	YES / NO	Tuberculosis_____	YES / NO
Stroke _____	YES / NO	Anaemia, Leukaemia or other blood diseases_____	YES / NO

Any other conditions. Please list _____

I have read and accept the privacy policy.

Signature_____ Date ____/____/____

List of all current medications – prescription, over the counter, herbal & alternative

Name of medication	What is it for? (what condition is it treating)	How much are you taking?	How long have you been taking it for?
PRESCRIPTION TABLETS			
OVER COUNTER PAIN RELIEF			
MINERALS/VITAMINS			
PATCHES/IMPLANTS			
SPRAYS/DROPS/CREAMS			