West Preston DENTAL

PATIENT HISTORY FORM

westprestondental.com.au Ph: 9478 0119 579 Gilbert Road, West Preston 3072

Mrs Miss Ms Mr Master Surname

First name Middle name Mobile

Home number Email

Home address Postcode

Emergency Contact (not at your address) Contact no.

Name of Medical Doctor/Clinic Contact no.

Are you responsible for your dental fees? Yes No (name of responsible person/s)

HOW DID YOU CHOOSE THIS PRACTICE?

Online Reviews Proximity Word of Mouth Website

Referral (please provide details) Other

MEDICAL HISTORY

Please answer yes if you have ever had, or suffer from the following:

	YES	NO
Rheumatic Fever		
High Blood Pressure		
Diabetes		
Heart Ailments		
Excessive Bleeding		
Infectious Diseases		
Epilepsy		
Hepatitis		
Kidney Disease		
Asthma		
Prosthetic heart valve		
Prosthetic joints		

MEDICAL HISTORY (CONT'D)

	YES	NO
Do you smoke? (Please indicate how many per day)		
Are you Pregnant? (Please indicate months)		
Allergies to Drugs (Please indicate)		
Other Serious Illnesses (eg cancer)		
Are you taking or receiving diphosphonates?		
Are you currently receiving any Medical Attention? (Please indicate below)		
Taking other Medicine or Tablets (Please indicate below)		

DENTAL HISTORY

How long since your last dental visit?

Are you nervous about treatment?

Have you had sore or bleeding gums when you brush?

Do you grind or clench your teeth?

Have you had any pain in the face, neck or back of head?

PREFERRED COMMUNICATION

Prior to your appointment, we will send a reminder about the details of your visit. Please inform your preferred method of communication:

Mobile Email Home phone

For routine appointments, we also send another reminder approximately a month before your appointment. Please inform your preferred method of communication:

Mobile Email Home phone

Letter None

I don't require any reminders thanks!

FOR CHILDREN 18 YEARS AND UNDER ONLY

Please provide medicare card details so we can check Child Dental Benefit Schedule eligibility on your behalf

No.:

Exp:

PATIENT'S SIGNATURE

DATE / /

Health information is treated with utmost confidentiality in accordance with Vic Health Records Act 2001 & Privacy Act. Disclosure will not be made to any person not involved in i) your treatment or ii) administration of this practice, without your prior written consent. If you have any queries please do not hesitate to raise the concerns with the practice.