# Innisfail Dentists Patient History Form

Title: ..... Given Name/s: ..... Surname: .....

Preferred Name: ..... DOB: ...../...../.....

Home Address: .....

Suburb: ..... Postcode: .....

Postal address (if different to above): .....

Ph: ..... Wk Ph: ..... Mobile: .....

E-mail: ..... Occupation: .....

Health Fund (Dental): .....

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

Medical Doctor: ..... Ph: .....

Is another member of your family a patient at our office? Name: .....

How did you find us? Website Google Facebook Walk-in Other: .....

Or who can we thank for referring you? .....

Please tick any that applies

## Habits

Smoke (per day) ☐

Chew tobacco (per day) ☐

Alcohol (per week) ☐

- ☐ High sugar/frequency
- ☐ Lots of fizzy/acidic drinks
- ☐ Recreational drugs

Details

## Warnings

- ☐ Pregnant or possibly pregnant
- ☐ Antibiotic Cover required
- ☐ Bruising or persistent bleeding
- ☐ Vertigo
- ☐ Anything dentist should know
- ☐ Do Not Recline
- ☐ Steroids within 2 years
- ☐ Warning Card
- ☐ Treatment requiring hospitalisation
- ☐ Dry Mouth

Details

## Heart

- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Heart Surgery
- ☐ Pacemaker fitted
- ☐ Heart Murmur
- ☐ Angina
- ☐ Thrombosis
- ☐ Other heart conditions

Details

## Chest

- ☐ Bronchitis
- ☐ Cystic Fibrosis
- ☐ Pleurisy
- ☐ Asthmatic
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Chest Surgery
- ☐ Other chest conditions

Details

## Blood

- ☐ Hepatitis B or C
- ☐ H.I.V.
- ☐ Abnormal Blood Test
- ☐ Blood refused by transfusion svce.
- ☐ Anaemia
- ☐ Sickle Cell
- ☐ Haemophilia
- ☐ Other blood conditions

Details

## Medication

## Allergies

- ☐ Penicillin
- ☐ Hay Fever
- ☐ Anti Tetanus Serum
- ☐ Eczema
- ☐ General Anaesthetic
- ☐ Local Anaesthetic
- ☐ Latex Allergy
- ☐ Medicines
- ☐ Plants
- ☐ Foods
- ☐ Aspirin
- ☐ Other allergy conditions

Details

## Other

- ☐ Liver Disease
- ☐ Diabetes (patient or family)
- ☐ Acid Reflux or Eating Disorder
- ☐ Bone or Joint Disease (osteoporosis)
- ☐ Fainting Attacks or Blackouts
- ☐ Past serious or infectious disease
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Hiatus Hernia
- ☐ Artificial Joint
- ☐ Giddiness
- ☐ Cancer (Radio/chemo)

Details

*Flip over →

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 give my permission for the practice to use the above contact details to send me appointment and preventative care recall reminders, and for product & service information or promotion.

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 service unless other arrangements have been made.

Signed by: Guardian/Patient: ..... Date: ...../...../.....

Name: .....

**ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED. AT ANY STAGE IF YOU HAVE CHANGED HEALTHFUNDS OR ARE PLANNING TO CLAIM THROUGH ONE OF THE FOLLOWING SCHEMES: VETERAN AFFAIRS, OR MEDICARE CHILD DENTAL BENEFIT SCHEME, PLEASE LET ONE OF OUR FRIENDLY STAFF MEMBERS KNOW.**

**Our Privacy Policy can be viewed on our website, www.innisfaildentists.com.au**