withers dental

305a Margaret Street, Toowoomba City, 4350
Ph: (07) 4659 9477
www.withersdental.com.au

CONFIDENTIAL MEDICAL / DENTAL HISTORY FORM

It is important to know details about your medical history as these could affect your oral health care (dental treatment). The information you provide is confidential and will be handled in accordance with our privacy policy which is shown on the second page of this form.

Last Name:		Title (eg. Mr/Mrs/Ms):
First Name:		Date of Birth:
Postal Address:		
Phone (Home):	Mobile:	Work:
Email:	What is your occupation?	
Contact in case of emergency:	Phone (Home):	Mobile:

REFERRED BY: ☐ **Yellow Pages** ☐ **Street Sign** ☐ **Website** ☐ **Patient / Friend (Name):** ____________________ ☐ **Other:** ____________________

	NO	YES	DETAILS
Are you being treated by a doctor at present:			
Are you taking any vitamins or prescribed medications at present?			*PLEASE LIST:*
ARE YOU TAKING, OR HAVE YOU TAKEN IN THE PAST FORTNIGHT? Blood thinners (Aspirin, Warfarin, Plavix, Heparin)			*Medication:*____________ *If Aspirin, what dosage?*____________ *If Warfarin, what is your most recent INR?*____________
ARE YOU TAKING, OR HAVE YOU EVER TAKEN Osteoporosis medicines (Bisphosphonates: Actonel, Fosamax, Merck, Aventis)?			
Do you normally require antibiotic cover before dental treatment?			*If yes, what for?*
Have you had abnormal reactions to local or general anaesthesia?			
Do you smoke?			
Are you pregnant *(females only)*			*If yes, which Trimester?*
Health Insurance?			*If yes, which fund?*
Who is your medical practitioner?			Phone:
Please list any drugs or medicines you are allergic to *(eg. Penicillin)*			
Please list any other known allergies *(eg. Latex)*			

Are you interested in improving your smile? ☐ YES ☐ NO Details: ____________________

Would you like your dentist to talk to you more about (Please tick): ☐ Whitening ☐ Veneers ☐ Crowns

☐ Braces ☐ White Fillings ☐ Children's Dentistry ☐ Wisdom Teeth ☐ Dental Implants

☐ Mercury Filling Replacement ☐ Anti-wrinkle Treatments ☐ Lip Enhancement ☐ Other Cosmetic Procedures

I have sensitive medical information that I wish not to write down. I would prefer to speak to a dentist about this *(tick box)* ☐

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? *(Please tick and provide requested details)*

	NO	YES		NO	YES		NO	YES
Hepatitis *(circle):* A / B / C			Prosthetic Heart Valve *DETAILS:*____________			Rheumatic Fever *WHAT YEAR:*____________		
Diabetes *Type (circle):* 1 / 2			Artificial Joint *SPECIFY:*____________ *DATE DONE:*____________			Heart Condition *SPECIFY:*____________		
Osteoporosis			Excessive bleeding			Cardiac pacemaker		
Epilepsy			Anaemia			Heart murmur		
Asthma			Kidney Disease			Stomach or digestive condition		
Bronchitis, emphysema or Other lung disease			Leukaemia or other blood disease			Radiation Therapy *WHAT REGION:*____________		
Thyroid disease			Liver Disease / Tuberculosis			Contact with HIV / AIDS virus		
Stroke			Steroid therapy			High blood pressure / Low blood pressure		
Depression								

Any other condition(s) (please specify):

I have read and accepted the privacy policy on the second page of this form. I understand that full payment is required on the day of treatment and accounts will not be issued.

Signature: Patient / Parent / Guardian:____________________

Date:_______/_______/_______

Office use only:

Please complete over page.

DENTAL QUESTIONS

When did you last see a dentist? ______________________

When was your last check – up? ______________________

When did you last have a professional clean? ______________________

Is there anything else you would like us to know? ______________________

____

	NO	YES
Do you feel you grind your teeth?		
Have you ever had orthodontic treatment?		
Have you ever had cosmetic dental procedures?		
Did you have fluoride during childhood?		
Do you currently experience pain with your teeth?		

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 and 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 necessarily 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 due 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 of the coping 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 from unauthorised access, modification or disclosure.
- Our staff are trained to respect these principles.

If you have any questions regarding the information we collect from you and hold in you dental records, please do not hesitate to ask us. We are acting in your best interests at all times. For a complete copy of our privacy policy please ask our friendly staff.

CONSENT FOR TREATMENT

1. I hereby authorise the dentist or designated staff member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
2. I authorise Withers Dental to use photographs taken of my dental treatment for their advertising material.
3. 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.
4. I agree to the use of anaesthetics, sedatives and other medications as necessary. I fully understand I can ask for a complete recital of any complications.
5. I agree to be responsible for payment of all services rendered on behalf of my dependants. I understand that payment is due at the time of service.

Patient's signature: ______________ Name: ______________ Date: _____/_____/_____

Parents / Responsible Party's signature: ______________ Relationship to patient: ______________

We accept all major cards, personal cheques, eftpos and cash.

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