Caring for life

Broad Oak Medical Dental

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of 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 third page of this form.

PATIENT DETAILS

Title	Mr / Mrs / Miss / Ms / Master / Other__________	Date of Birth ___________________	
Given Names		Preferred Name	
Surname			
Occupation			
Phone (H) Phone (M)	☐ ☐ (Please tick your preferred contact)	Home Address	
Email Address			
Medicare card no			
Pension or DVA no			
Health Fund (if applicable)		Member Number	
Country of Birth			
Emergency Contact	Name: Phone Number: Relationship		

MEDICAL HISTORY

Have you ever had or are you suffering from any of the following? Please tick any that apply:

☐ Diabetes – Type I or II	☐ Kidney Disease	☐ Prosthetic implant
☐ Heart Disorder/Complaint	☐ Excessive Bleeding	☐ Cardiac Pacemaker
☐ Asthma	☐ Stroke	☐ Stomach or Digestive Condition
☐ Steroid Therapy	☐ Cancer	☐ Hepatitis or Other Liver Diseases
☐ Radiation Therapy	☐ Chemotherapy	☐ Tuberculosis
☐ Lung Disease (eg. Bronchitis)	☐ Rheumatic Fever	☐ Thyroid Disease
☐ Blood Disease (eg. Anaemia)	☐ Bone Disease (eg. Osteoporosis)	☐ Nervous or Psychiatric Condition
☐ Epilepsy	☐ High or Low Blood Pressure	☐ Fainting Disorder
☐ Sleep Apnoea	☐ Contact with HIV/AIDS	☐ Transplanted organ or marrow

List of medications if any:

Name of Allergies if any:

What are the allergic reactions:

Are you taking any medication (over the counter, prescribed or vitamins)? Please provider details:

For Women: Are you pregnant? If so, how many months?

Do you drink alcohol? If yes how many per week?

Do you smoke? If so, how many per day?

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DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? Please tick any that apply

☐ Sensitivity to hot or cold	☐ Food trapping between teeth	☐ Clicking/pain in the jaw joints
☐ Staining of your teeth	☐ Discoloured fillings or teeth	☐ Roughness of existing fillings
☐ Bleeding gums	☐ Bad breath	☐ Sensitivity when eating
☐ Head/Neck Ache	☐ Grinding/clenching of your teeth	☐ Existing crowns/bridges/dentures
☐ Crowding of teeth	☐ Missing teeth/spaces between teeth	
What is the main purpose of your visit today?		
How long since your last dental visit?		

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐Moderately ☐Extremely

How did you hear about us?

REFERRAL INFORMATION

☐ Internet/Website ☐ Walk-By ☐Brochure in letter box ☐Other____________________________

☐ Friend/Family (please provide name so that we can thank them)____

- I, the undersigned am aware that payment is required on the day, unless arranged with the practice in advance.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment, and that a cancelation fee may be charged if I fail to do so.
- I have provided an accurate medical and dental history, to the best of my knowledge
- I have read and accepted the following privacy policy

Signature: Patient/Parent/Guardian: ____

Date: ____

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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 tis 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 unnecessarily 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 undue 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 or the copying 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 and from unauthorised access, modification or disclosure.
- Our staff are trained to respect these principles at all times.

If you have any questions regarding the information we collect from you and hold in your dental records, please do not hesitate to ask us. We are acting in your interests at all times.