MEDICAL HISTORY & CONSENT ADULT & YOUTH

DENTAL

Personal Details:			
Title (please circle)	**Mr Mrs Ms Miss**	**Date of Birth**	**Mobile No.**
First name		**Surname**	
Postal Address			
Health Fund	**Membership No.**	**Medicare**	**Card No:**
	Patient ID:		**Patient ID:**
Emergency Contact		**Contact Phone No**	
Doctors Name		**Clinic Phone No**	

Medical History – IF YOU ARE UNCERTAIN ABOUT ANY QUESTION PLEASE DISCUSS WITH YOUR DENTIST: Certain medical conditions make you susceptible to infections and disease, and failure to make full disclosure may place you at risk.

Have you been affected by the following?	**Circle Answer**	**Have you been affected by the following?**	**Circle Answer**
Stayed in Hospital, had an operation or general anaesthetic?	YES / NO	Steroid therapy	YES / NO
Heart Problem; Murmur/Artificial Heart Valves?	YES / NO	Transplanted organ or bone marrow	YES / NO
High blood pressure?	YES / NO	Anti-coagulant therapy	YES / NO

A stroke?	YES / NO	Dementia of less than 12 months duration with an un-diagnosed cause?	YES / NO
Do you smoke / Drink alcohol	YES / NO	Radiation therapy / Chemotherapy?	YES / NO
Rheumatic fever?	YES / NO	Kidney disease?	YES / NO
Lung conditions / Asthma / bronchitis	YES / NO	Psychiatric treatment / Depression / anxiety	YES / NO
Diabetes?	YES / NO	Joint problems / Arthritis?	YES / NO
Hepatitis A, B or C / Tuberculosis	YES / NO	Thyroid disease	YES / NO
HIV / AIDS / Intravenous drug user?	YES / NO	Sinus trouble	YES / NO
Blood transfusion?	YES / NO	Gastric ulcer / digestive conditions	YES / NO
Aspirin / Bisphosphonate medications / Excessive bleeding?	YES / NO	For **women:** Are you pregnant	YES / NO
Epilepsy	YES / NO	Jandice or other liver diseases	YES / NO

CURRENT MEDICATIONS (please list below)			
Drug	Strength (mg)	Number of times taken per day	Time & Date last taken
List any Allergies and / or Medical conditions /A reaction to any tablets, medicines or latex?			

Consent:

I declare that the information on this form is true and correct. I understand that failure to make full disclosure may place me at risk. I acknowledge that the nature, implications and risks of the proposed treatment plan have been explained to me and I consent to receive dental treatment check up and any treatment required after examination.

Failure to attend an appointment without giving adequate notification will incur a broken appointment fee which is required to be paid before we can provide you with further appointments.

Signature		Date:	

Southern Breeze Dentistry is committed to protecting your privacy. Information collected on this form will be recorded in your dental record, in accordance with privacy legislation.