Legana Dental Medical History Form

Full Name (Mr/Master/Mrs/Miss/Ms/Dr/Other): _____

Postal Address (including suburb & postcode): _____

Home Phone: _____ Work Phone: _____Mobile: _____

Preferred daytime contact: Home / Work / Mobile *(please circle)* Date of Birth: _____

Email Address: _____ Occupation: _____

Family Doctor: _____ Doctor's Surgery: _____

Do you have Private Dental Insurance? □ **YES** □ **NO** If yes, please specify fund name _____

Emergency contact (NAME, RELATIONSHIP & PH NUMBER): _____

How did you hear about us? _____

I have private and confidential medical matters which I wish to discuss with the dentist? □ **Y** □ **N**

Are you of Aboriginal or Torres Strait Islander origin? □ Y □ N

Please indicate YES or NO if you have <u>ever</u> had any of the following:

	Y	N		Y	N
ADHD / Autism			HIV/AIDS		
Anxiety			Jaw, neck or shoulder injury or pain		
Asthma/Bronchitis/lung conditions			Joint replacement surgery (please specify if yes) ……		
Blood disorders			Kidney/renal disease		
Chemotherapy/radiation therapy Area ……			Osteoporosis or low bone density		
Depression			Nervous system disorder E.g. MS, Alzheimer's or Parkinson's		
Diabetes or family history of diabetes			Rheumatic Fever		
Epilepsy/Seizures			Rheumatoid arthritis/Lupus/Polymyalgia		
Excessive bruising or bleeding			Snoring/Sleep Apnoea		
Gastroesophageal reflux disease			Thyroid Disease		
Heart Condition/Cardiac Surgery/Pacemaker			Transplanted organ/bone marrow/stem cells		
Heart valve replacement			Treatment for cancer (type/region) ……		
Hepatitis B/C or liver disease			Tuberculosis (TB)		
High or low blood pressure					

Do you currently smoke? □ Y □ N If yes, how many per day? _____

Do you currently use illicit substances and/or reactional drugs? □ Y □ N

<u>For Women:</u> Are you currently pregnant? □ Y □ N If yes, how many weeks_____

Are you on any of the following medications? (Please tick those that apply)

□ Cortisone (Prednisolone) □ Diabetes (Diabex) □ Osteoporosis (Fosamax/Actonel/Prolia)

□ Blood thinning (Aspirin/Warfarin/Plavix/Xarelto/Clopidogrel/Dabigatran/Rivaroxaban/Apixaban) P.T.O

Please list any medications you are taking? (including prescription and non-prescription) If you have a medications or health summary list, please let our staff know so we can scan it into your patient file.			
Drug Name	Dose Taken	Duration of Use	Purpose/Notes

Allergies/Adverse Drug Reaction – especially antibiotics (e.g. Penicillin), medicines, antiseptics, latex, local anaesthetics etc		
Drug Name	Nature of reaction	When reaction occurred

Would you like to receive your appointment reminders via SMS? □ YES □ NO

(Note: if you tick "NO" you will receive a reminder phone call to your preferred contact method).

If you would like to receive a check-up reminder, please indicate below preferred method.

□ 6 months □ 12 months / □ Email □ SMS

(Note: Please leave blank if you wish not to receive a recall reminder)

Please read the following statement carefully and sign below:

Payment is required on the day of treatment. Cash, EFTPOS and Credit Cards (MasterCard, Visa) accepted. No fee is charged for credit card use. Private health insurance claims are processed on the spot using HICAPS. In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs. All appointments require 24-hour cancellation notice, failure to provide this notice and you could incur a cancellation fee of $50. This fee also applies to any appointments that you fail to attend.

Please only sign if you are above the age of 18, otherwise a parent/guardian must do so.

Signature: _____ Date: _____

Full Name: (BLOCK LETTERS) _____

OFFICE USE ONLY – medical history update checks. These should be completed annually.

1st update signature: _____ 2nd update signature: _____

Date: _____ Date: _____

New Medical History to be completed after 2 updates.