AMR DENTAL

PATIENT MEDICAL HISTORY

To aid us in thoroughly evaluating your present dental condition, please complete this questionnaire. This information will form an important part of your surgery record and will be held in the strictest confidence.

Surname _____First Name _____DOB _____
Home address _____
Postal address (if different) _____
Phone number: Home_____Work_____Mobile_____
Email address_____
Occupation _____
Medical Doctor's name_____
Do you have any private ancillary health insurance? ☐Yes No☐ Name of fund _____ Member#_____ Ref#____
Contact person (in case of emergencies) _____ Phone number_____

MEDICAL HISTORY

Are you receiving any medical treatment now? If so, what for? _____
_____
Do you have any allergies to penicillin, any other drugs/medicines, latex or any other allergies? If so, please specify
_____
Have you ever had excessive bleeding requiring special treatment? _____
Do you bleed or bruise easily? _____
Do you take any prescription drugs regularly? Which ones?
_____

When was your last visit to the dentist? _____ Females - are you pregnant? ☐Yes No☐
Have you ever had any of the following:

a) Heart trouble (Including heart murmur or artificial valves)	☐Yes No☐	h) Epilepsy	☐Yes No☐
		i) Osteoporosis	☐Yes No☐
b) Cortisone therapy	☐Yes No☐	j) Anaemia	☐Yes No☐
c) Diabetes or high blood pressure	☐Yes No☐	k) Jaundice	☐Yes No☐
d) Family history of diabetes	☐Yes No☐	l) Chemotherapy/ radiation therapy	☐Yes No☐
e) Rheumatic Fever	☐Yes No☐	m) Artificial joint replacements e.g. hip/knee	☐Yes No☐
f) Hepatitis b or c	☐Yes No☐	n) High blood pressure	☐Yes No☐
g) HIV or AIDS	☐Yes No☐	o) Low blood pressure	☐Yes No☐

Any other medical conditions not mentioned above _____
Do you smoke/vape? ☐Yes No☐ If so, for how many years?_____
Do you suffer from bleeding gums? ☐Yes No☐ Bad breath? ☐Yes No☐
Do you have six-monthly Prolia injections? ☐Yes No☐
If you have anything you wish to discuss with your dentist in private, please tick ☐

We require payment for service on the day of treatment.
Please indicate your preferred payment method to settle your account today:
Cash ☐ EFTPOS ☐ Credit Card ☐ Other ☐
As a courtesy to this surgery, 24 hours' notice is required if you are unable to attend your scheduled appointment.
We reserve the right to add additional administrative fees if terms of trading are exceeded.
All information is treated with complete professional confidentiality.
I, the undersigned, agree to abide by these requests.

Signature: _____ Date: _____