Minto Dental SURGERY

T 02 9820 4161
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8 Minto Road
Minto NSW 2566

Medical History Form

To help the dentist perform a complete dental examination, the following questionnaire has been formulated. Please answer the questions as accurately as possible. This information will be held confidential. Thank You.

Mr / Mrs / Miss / Ms / Dr ……………………………………………………………………..Date of Birth………...............
(Surname) (Given Names)

Home Address....………

Home Phone……………………………….. Mobile…………………………………………………

Email Address………………………………………………………………………………………

Parent / Guardian……………………………………………………………………………………

Health Fund or Dental Cover (if any)…………………………………………………………......

In the event of emergency, Name…………………………………. Phone……………………….

Address………………………………………………………………………………………………

Please answer each of the following

1. Medical Practitioner's (GP) Name………………………………………………………Suburb……………………………
2. State any medicines you are taking now (e.g. pain killers, antibiotics, steroids, etc.) – please use reverse of page if insufficient space.

   ………………………………………………………………………………………………..
3. State any allergy to penicillin, iodine, adrenalin or medicine.

   ………………………………………………………………………………………………..
4. Have you had any excessive bleeding requiring special treatment?

   ………………………………………………………………………………………………..
5. Are you taking Hormone Replacement Therapy and/or Fosamax? ....
6. Tick any of the following which you have had:

__ Heart Trouble	__ Epilepsy	__ Jaundice
__ Diabetes	__ Rheumatic Fever	__ High Blood Pressure
__ Radiotherapy	__ Stroke	__ Tuberculosis
__ Asthma	__ Anaemia	__ Arthritis
__ Cancer Treatment	__ Hepatitis A B C (Please circle)	__ other………………………………..

7. Do you have a medical condition which requires Antibiotics prior to Dental treatment (e.g. Joint replacement / Hip Replacement)? Yes / No
8. (Women) Are you Pregnant now? .... If yes, When Due? ………………………………………
9. Have you ever had: a. abnormal reaction to any of the anaesthetics used in dentistry? Yes / No

   b. Post Dental treatment problems? Yes / No
10. Have you previously attended this dental practice? Yes / No
11. Are you a Smoker? Yes / No

PLEASE READ BEFORE SIGNING – I understand that the trading policy of this surgery is payable on the day of the treatment. An administration charge may be added if I fail to settle my account within 7 days. In the event of default, I agree to meet the cost of any debt collection fees incurred. If you are unable to keep your appointment, notice of 24 hours is required, otherwise A BROKEN FEE MAY BE CHARGED. Your assistance and courtesy in this matter will be greatly appreciated.

Date…………………………………….. **Signature**………………………………………………