Beeliar Village
6/8 Durnin Ave, BEELIAR, WA 6164
Ph: (08) 9437 5999 email: reception@beeliardental.com.au
www.BeeliarDental.com.au

We would like to welcome you to our practice. To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire. Thank you.

Personal Information

Title: _____ **Family Name:** _____**Given Name**: _____

Address: _____WA_____

Date of Birth: _____ **Email:** _____

Telephone (M): _____ **(H):** _____ **(W):** _____

Private Health Fund:_____ **Member ID:**_____ **I.D:**____

Preferred method of communication: ☐Home phone ☐Work phone ☐Mobile/SMS ☐email

Employer: _____ **Occupation:** _____

How did you find out about us: ☐Internet ☐Local Paper ☐Mail Drop ☐Village Visit ☐Friend/Patient

If referred by a person please give details so that we can thank them? _____

Medical History

I have private and confidential medical information which I do not wish to write down. I prefer to speak with the dentist about this. Yes /No

Are you at present receiving medical treatment? Yes /No

Have you been a patient in a hospital in the last two years? Yes /No

If yes, please give brief description and approximate date: _____

_____

Are you taking prescribed/non-prescribed or natural therapy medications? Yes /No

Please list all medications/drugs being taken: _____

_____

Do you or have you ever taken Bisphosphonates eg Fosamax Yes /No

Ladies: are you possibly pregnant? Yes (due date: _____) / No

Have you experienced any allergic reactions or unusual effects from any medications, anaesthetics, chemicals or substances? Yes /No

If yes, please give brief description: _____

_____

Do you smoke? Yes /No

Please Turn Over

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Have you ever suffered from any of the following conditions?

- ☐ Penicillin Allergy
- ☐ High Blood Pressure
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Hepatitis, Jaundice or Liver conditions
- ☐ Diabetes
- ☐ Kidney conditions
- ☐ Gastric ulcers
- ☐ Cold sores
- ☐ Blood disorders
- ☐ Haemophilia
- ☐ HIV/Aids
- ☐ Bronchitis
- ☐ Epilepsy
- ☐ Depression
- ☐ Nervous System Disorder
- ☐ Thyroid conditions

Have you ever had:

Transplant Surgery? Yes /No

Details: _____

Prosthetic Surgery (i.e. artificial joints, heart valves etc.)? Yes /No

Details: _____

Any infectious/non-infectious conditions not previously listed? Yes /No

Details: _____

Any Heart complaints/Cardiac Pacemaker etc.? Yes /No

Details: _____

Name of Doctor: _____ **Practice Name:** _____

Dental History

Previous Practice Name: _____

Treating Dentist: _____

Approximate date of last visit: _____

Do you experience excessive bleeding/bruising following treatment? Yes /No

Do you become anxious or uncomfortable during dental treatment? Yes /No

Do you have a dental problem at present? Yes /No

Details: _____

By signing this form I acknowledge that this represents an accurate medical history and I will supply details of any changes to this history.

Signature_____ Date: _____

Signature_____ Date: _____

Signature_____ Date: _____

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Patient Privacy Consent

Beeliar Dental Care operates in accordance with and is bound by the National Privacy Principles under the Privacy Act of 1988 (NPP). The NPP govern the way that we collect information from you which is necessary for us to provide you with dental health care. The NPP also governs the way that we store this information in your dental records cover, how we use that information and how you may have access to your dental records.

It is understood that you have given general consent to us to disclose information imparted by you, in order to provide you with optimal dental care. For example other dental practitioners, specialists and registered health care providers where, in our opinion, this is beneficial to your overall dental and general health.

It is very important that you keep us fully informed of matters affecting your general and dental health, irrespective of whether they are of a temporary nature – such as changes in current medication – or of a more permanent nature. If you fail to provide us with any relevant health or other information you may compromise the level of dental care that we are able to provide and could in extreme situations put either your general or dental health at serious risk.

I have read and understood the above.

Name: _____

Signature: _____

Date: _____