'Our family caring for yours'

www.cfdental.com.au
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Shop 1, 748 Nicklin Way,
Currimundi, QLD

It is important for us to know details about your medical history as these could affect the success of your dental treatment. The information you provide is confidential and will be handled in accordance with the Australian Dental Association privacy policy.

PATIENT HISTORY FORM

Title: Mr / Mrs / Ms / Miss / Master / Dr / Other ______________

First Name: ______________________
Last Name: _______________________

DOB: __________ Gender: M / F

Do you have a health fund? Y / N
Fund: ___________________________
Membership Number: _______________series #____
Medicare Number: _________________ series #____

Email Address: ______________________________

Street Address: ______________________________
____

Mobile: ___________________________________
Home: ____________________________________
Work: _____________________________________

Occupation: _________________________________

In case of an emergency, please list an alternative contact person
Name/Relationship: ____________________________________ Phone Number: ___________________

Who is your medical practitioner? _________________ Phone Number: ___________________
Are you currently being treated by a doctor? Y/N Details: _____________________

Have you ever undergone a sleep study? Y/N If so, when/where: ______________
Do you suffer from snoring? Y/N
Do you suffer from sleep apnoea? Y/N

Are you currently taking any prescribed or over the counter medications? Y/N
If so, please list:

How did you hear about us (circle below)?
Google Facebook Radio Yellow Pages Letterbox Drop
Nicklin Way Sign Buderim Street Lightbox Chemist Sign Drive by/ Walk in
Referral From ____________ School Visit At ____________ Other (please specify) ______________

If you are interested in improving the condition/appearance of your teeth, in what way? (please circle)
Healthier / Whiter/ Less Sensitive / Stronger/ Straighter / Replace Missing Teeth/Other ____________

Do you have any problems or fears related to dental treatment? Y/N

If so, please explain____

____

PLEASE TURN OVER

MEDICAL HISTORY:

	Y/N	Details
Do you normally require antibiotic cover before dental work?		
Have you had any abnormal reactions to local or general anaesthesia?		
Are you allergic to any medicines or drugs?		
Do you have any other known allergies? (including latex)		
Do you smoke?		
Are you pregnant?		

Do you have, or have you had any of the following medical conditions? (tick yes or no)

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Anaemia			Asthma			Blood Disorder		
Cardia Pacemaker			Diabetes			Epilepsy		
Excessive Bleeding			Heart Complaint			Heart Murmur		
Heart Valve Disorder			Hepatitis A, B or C			High Blood Pressure		
HIV/AIDS			Kidney Disease			Leukaemia		
Liver Disease			Lung Disease			Nervous Condition		
Osteoporosis			Prosthetic Implant e.g. Artificial Hip			Radiation Therapy		
Rheumatic Fever			Stomach/Digestive Condition			Stroke		
Thyroid Disease			Transplanted Organ/Marrow			Tuberculosis		

Please list any other relevant medical conditions: ____

Are you taking anticoagulant medications (e.g. Warfarin, Plavix)? Y/N If so, please specify

____

Are you taking bisphosphonates (e.g. Fosamax)? Y/N If so, please specify

____

Would you like to receive txt and/or email correspondence for appointments confirmations and the newsletter? Yes / No

CANCELLATION POLICY

Your appointment time is reserved especially for you. If you cancel or change without adequate notice this prevents us treating another patient who may require our services. I, ____________________________, have read and understood the above condition of being a patient at this practice, and agree to pay a cancellation fee of $50 should I cancel without giving 24 hours' notice. I acknowledge that the information given on this form is true and accurate to the best of my knowledge. By signing, I give permission for Coast Family Dental to contact me via SMS, email or phone.

Signature: ____ Date: ______________________________

******OFFICE USE ONLY******

***Dentist Sign:*________________*Date:*___/___/_____**