StKildadentist
Quality Contemporary Dentistry

Medical History Questionnaire

Mr Mrs Ms Other

First Name ____________________ Surname ____________________

Preferred Name ____________________ Date of Birth ____________________

Mobile Number ____________________ **Email** ____________________

Home address ____

____________________ 2nd contact number ____________________

Postal address (if different from home address) ____________________

____

Emergency Contact ____

Relationship ____

Contact Number ____

Medical Doctor:

Name ____________________ Address ____________________

____

Contact Number ____

How did you hear about us?

- Google
- Website
- Walk by
- Yellow Pages
- Advert
- Referred by your GP
- Personal Referral (please write their name as we would like to thank them) ____________________

Notice to insured patients regarding dental benefits insurance

Item numbers on our statement represent as accurately as possible the procedures performed, but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures, to attract refunds and the rates of those refunds, are determined by the conditions of the patient's Health Insurance Policy. We accept no responsibility, to either party for any decisions the Insurer may make regarding the refund of monies to the patient.

Do you suffer from any of the following? Please indicate

	yes	no
High blood pressure		
Heart ailment		
Rheumatic fever		
Asthma, chest or breathing problems		
Tuberculosis		
Stomach or bowel problems (eg ulcer)		
Kidney disease		

	yes	no
Diabetes		
Depression (needing medication)		
Excessive bleeding or blood disorder		
Epilepsy		
Hepatitis		
AIDS/HIV		
Osteoporosis or bone tumour		

Do you smoke? Yes No How many? _______ / day

List any other previous illness: ____

	yes	no
Would you like to discuss these questions in private with the dentist?		
Do you have an artificial hip, heart valve or other prosthetic implant?		
Have you ever had problems with dental treatment?		
Are you presently under medical care?		
Are you taking any drugs, medicines or tablets?		

If yes please list: ____

	yes	no
Female patients, are you pregnant?		
Do you have allergies?		

Please list any medicines or products you are allergic to (e.g. Penicillin, Latex ...): ____________________

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THANK YOU FOR YOUR ASSISTANCE IN FILLING OUT THIS FORM AS FULLY AS POSSIBLE

I have completed this Questionnaire to the best of my knowledge, and understanding that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check up reminders.

Signature ____________________ Date ____________________

Your Health Information - Privacy Consent Form

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.
The policy of our practice is to follow these procedures:

1 The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2 We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

3 We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4 Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5 If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.
You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Signed: ______________________________

Date: ______________________________

Patient/ Parent / Guardian Name: ______________________________

Dependents: ______________________________