

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE

PATIENT HISTORY SHEET

TITLE: (Mr, Mrs, Miss, Ms, Dr) FIRST NAME: SURNAME :

HOME ADDRESS: POSTCODE:

HOME NUMBER: MOBILE:

WORK: DATE OF BIRTH:

POSTAL ADDRESS (if different from above):

NAME OF PERSON RESPONSIBLE FOR FEES:

ADDRESS (if different from above):

EMERGENCY CONTACT: RELATIONSHIP:

CONTACT NUMBER:

MEDICAL DOCTOR: CONTACT NUMBER:

ADDRESS:

WHO RECOMMENDED THIS PRACTICE TO YOU?

If possible provide approximate date of diagnosis

High blood pressure

Kidney disease

Bone Diseases/ Osteoporosis

Heart Ailment

Diabetes

Stomach / bowel problems

Rheumatic fever

Thyroid problems

Hepatitis

Epilepsy

Tuberculosis

AIDS / HIV

Asthma, Chest or breathing problems

Mental health/ Psychological issues

Back / Neck / Jaw problems

Cancer (if so where)

List any other previous illness / comments:

Do you have an artificial hip, heart valve or other prosthetic implant?:

Yes / No

Problems with previous dental treatment:

Yes / No

*continued over page ...*



Are you presently under medical care for any illness?: Yes / No

Are you pregnant? Yes / No

Do you have Private Health Insurance? Yes / No

Do you smoke? Yes / No

If yes, how many per day:

Do you drink alcohol? Daily

Weekly

Monthly

Approximate number of drinks:

Please list any allergies:

Are you taking any drugs, medicines or tablets? Please list:

Privacy policy: We need the information set out above to provide you with effective and efficient dental services. You are

entitled to access your information at anytime and we will keep your information confidential, if necessary, however, we may pass your information on to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies.

terms of payment: I accept responsibility for my account and understand that the fee is payable on the day. Should I be unable to pay on the day I understand the payment is due within 30 days; if my account exceeds 30 days I understand an account keeping fee may be incurred. If my account remains overdue and is referred to a debt collection agency or solicitors, I may be held liable for the cost of such collection plus interest. I accept full responsibility for health fund claims and rejections. Any fees incurred by the practice for cheques not accepted by the bank may be passes to me.

SIGNED: DATE:

THANK YOU!