Camp Hill Dental
a reason to Smile

MEDICAL HISTORY FORM

We respect your privacy and all records are kept strictly confidential.
We abide with the provisions of the Privacy Act 1988 (Cth).

SURNAME: _____Mr /Mrs /Miss /Ms /Master /Dr (please circle)

FIRST NAME: _____ I PREFER TO BE CALLED:_____

DOB: _____/_____/_____
ADDRESS:_____

_____POSTCODE: _____

MOBILE: _____EMAIL:_____

HOME PHONE: _____ OCCUPATION: _____

PRIVATE HEALTH INSURANCE (Health Fund): _____LINE NO:_____

LAST DENTAL VISIT? _____

LAST DENTAL X-RAYS TAKEN (please circle): LESS THAN 1 YEAR LONGER THAN 1 YEAR NEVER

The name of your GP (doctor): _____ SUBURB: _____

Emergency Contact & Phone Number: _____

Please specify and tick the box if you have, or have ever had, any of the following:

- ○ Blood pressure: High
- ○ Blood pressure: Low
- ○ Blood disorders e.g. anaemia
- ○ Taking blood thinners
- ○ Excessive bruising/bleeding
- ○ Cardiac Pacemaker or stents
- ○ Congenital Heart Defect
- ○ Heart Disease
- ○ Artificial Heart Valves
- ○ Rheumatic/Scarlet Fever
- ○ Stroke
- ○ Asthma
- ○ Diabetes
- ○ Artificial Bones/Joints
- ○ Epilepsy/Seizures
- ○ Lung Disease/Tuberculosis
- ○ Hepatitis:
- ○ Kidney disease
- ○ Thyroid Disease
- ○ Osteoporosis
- ○ Cancer
- ○ Radiation or Chemotherapy
- ○ Anxiety/Depression
- ○ Eating Disorder
- ○ Mouth Ulcers/Cold Sores
- ○ Reflux
- ○ Hay fever/Sinus Problems
- ○ Snoring/Sleep Apnoea
- ○ Migraines/Headaches
- ○ HIV/Aids
- ○ Recent Hospitalisation
- ○ Smoking _____ per day

Other conditions (specify):
_____

Are you: currently pregnant or breast feeding: _____ Expected date of your baby's arrival :_____

Do you have any allergies? **YES / NO** Please specify_____

This includes: Penicillin/Other Antibiotics, Latex, Nitrous Oxide, Anaesthetics incl Adrenaline, Codeine/Other Pain Killers, Bees, Foods.

List ALL MEDICATIONS:_____
_____

_____
_____

_____
_____

(including over the counter & any herbal/naturopathic supplements, such as glucosamine, St John's Wort)

How do you feel when you come to see the dentist? (mark with an X)

|_____|_____|_____|_____|_____|_____|_____|_____|
NOT ANXIOUS EXTREME PHOBIA

Are you anxious because:

- Previous dental experience
- Cost of dental treatment
- Not happy with results
- Do not understand dental lingo
- Fear of showing anyone my teeth
- Not feeling welcome or a prior experience

Do you wear a night guard/splint for jaw issues? **YES / NO** Have you had orthodontic treatment? **YES / NO**

Have you ever had periodontal (gum) treatment and/or are you seeing a periodontist at present?

YES / NO

Have you had any dental concerns in the following areas: (please tick)

- Receding gums
- Bleeding gums
- Swelling, ulcers, lumps
- Cold sores
- Dry mouth
- Unpleasant breath
- Teeth sensitivity
- Broken or chipped teeth
- Teeth hurt when biting
- Throbbing / tooth ache
- Wisdom teeth problems
- Issues with flossing/floss tearing between teeth
- Missing teeth
- Denture concern
- Grinding and clenching
- Sore/clicky jaw
- Head and neck aches
- Unattractive smile

Would you like more information on teeth whitening? **YES / NO**

Would you like more information on changing the shape, look and position of your teeth?
YES / NO

What is your Secret Dental Wish:

_____

Would you like to receive our monthly dental newsletter? YES / NO

Consent for Treatment

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
2. I agree to the use of anaesthetics, sedatives, and other medication as necessary. I fully understand that using anaesthetics agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
3. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made prior. I also authorise you to obtain payment from my Private Health Insurance where applicable.
4. I understand appointments not kept or cancelled within 24 hours may incur a non-attendance fee.

WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE

WE ACCEPT ALL MAJOR CREDIT CARDS, AMEX, AFTERPAY, PERSONAL CHEQUES, EFTPOS & CASH.
We have a HICAPS facility at our Practice for quick and easy claims with your Health Fund.

Patient/Parent/Legal Guardian
Signature_____Date____/____/20_____
Thank you for filling out this form as it helps us design your individual dental treatment more accurately and successfully

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SMILES FOR LIFE

NOTICE OF PRIVACY POLICIES

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_____

Name:_____ _____Date of Birth :_____

Address:_____Ph:_____ _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Privacy Act 1998 (CHT). I

understand that by signing this consent I authorise you to use and disclose my protected health information to carry out:

- Treatment (incl direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. Private health insurance company)
- The day-to-day healthcare operations of our dental practice

I have been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights. I understand that Camp Hill Dental are then bound to comply with this restriction.

CONSENT FOR TREATMENT: I hereby grant authority to the dentists in charge, of the care of the patient whose name appears on the Health History form, to administer such anaesthetics, analgesics, sedatives and nitrous oxide sedation (if necessary) and to perform such operations as may deemed advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures. I acknowledge that I may ask further questions about my proposed treatment options and associated costs at any point in time.

_____

Signature

Could you kindly tell us how did you find out about our dental practice (please tick or circle)

Family **Friend / Work Colleague** **NAME:** (so we can thank them) _____

Doctor **Sign** **Local**
Website **Facebook** **Instagram** **Google**
Booking on Health Engine **Preferred Provider** **Booking on Website**
Other _____