NORTHEND DENTAL CO.

It is important to know details about your medical history as it may affect your dental treatment.

PATIENT DETAILS			
Title	Mr. /Mrs. /Miss. /Ms. /Master / (Other)		
Given Name(s)			
Surname		**Date of Birth**	/ /
Contact Number	(This number will be used for primary correspondence unless discussed otherwise and to send appointment reminders when required) Please let us know if you do not want SMS reminders.		
Address			
Occupation			
Private Health Insurance (if applicable):			
How did you hear about us?			
Emergency Contact	Name Phone Number		

MEDICAL HISTORY		
Doctor's Name and Contact details		
Have you ever had/are suffering from any of the following? Please tick those that apply:		
□ Diabetes	□ Blood Pressure (High or Low)	□ Epilepsy
□ Heart problems/complaints	□ Stroke	□ Sleep Apnoea
□ Kidney Disease	□ Excessive Bleeding	□ Cancer
□ Liver Disease or Hepatitis	□ Rheumatic Fever	□ Tuberculosis
□ Asthma	□ Bone Disease- osteoporosis	□ Stomach or digestive conditions
□ Prosthetic Implants	□ Cardiac Pacemaker	□ Thyroid Disease
□ Nervous or Psychiatric Condition	□ Radiation or Chemotherapy (Past or Present)	□ Steroid Therapy (Past or Present)
□ Allergy to Latex	□ Allergy to Penicillin	□ Allergy to Medications (list below)
Any other condition(s)? Please list:		
Have you been a patient in hospital within the last 2 years? If yes, please provide more information.		
Pregnant: Yes/ No	Breastfeeding: Yes/ No	

Are you taking any medications (prescription or over-the-counter)? If yes, please list.
Do you smoke? YES/ NO If so how many per day?

DENTAL HISTORY	
Date of Last Dental Visit:	
Reason for Dental Visit:	

I certify that I have read and understood the above information. To the best of my knowledge, the questions have been answered accurately. I understand that providing incorrect information may be dangerous to my health.

Signature (Patient/Guardian) _____ Date ____/_____/ 20___

Thank you and welcome to Northend Dental Co.

Privacy Policy –

The information collected will be used for the purpose of providing treatment to you. Personal information will be used for correspondence, processing payments and any information regarding your treatment. We may disclose your health information to other health care professionals, or require it from them if it is necessary in the context of your treatment.
Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept at Northend Dental Co. If any information we have about you is inaccurate, please inform us so that we may correct it. If you have any queries or concerns about us handling of your health information, please do not hesitate to raise these concerns with our practice.