Medical History Form

Kelmscott Dental

Personal Details

Date of birth ...../...../..... Title (Dr/Mr/Mrs/Ms/Miss/Master)
Patient Name.....
First Name Middle Surname
Address.....
Suburb..... Postcode.....
Phone (Home) .....(Mobile) .....(Work).....
Email Address ..... Drivers License No.....
Private Health Fund..... Number .....(.....)
Department of Veterans Affairs: .....
(If under 18) Guardian Name..... (Phone).....
Occupation.....Employer.....

Contact Information:

How would you like to receive recalls: ☐ SMS ☐ Email ☐ Phone Call ☐ Letter
How would you like to receive appointment confirmations: ☐ SMS ☐ Email ☐ Phone Call

Would you like to join our FREE Dentisure? (Dental Insurance) ☐ Yes ☐ No
(must have an email address)

Who may we thank for referring you to our practice?

☐ Friend/Family (Name of Person) .....($50 voucher will be sent)
☐ Our Website ☐ Yellow Pages (local/online) ☐ Internet Search (Google)
☐ Other Dentist ☐ The Comment News ☐ Armadale Examiner
☐ The Local link ☐ Other .....

Medical/Dental History

When did you last visit a dentist? .....
When did you last have Oral x-rays: ☐ 6-12 months ☐ 12 + Months
How often do you:
Brush your teeth ☐ Twice Daily ☐ Once Daily ☐ Other.....
Floss ☐ Twice Daily ☐ Once Daily ☐ Other.....
Rinse with mouth wash ☐ Twice Daily ☐ Once Daily ☐ Other.....

Please circle '**yes**' or '**no**' for the following:

Suffered from a stroke	Yes	No	Previous operations	Yes	No
Irregular blood pressure	Yes	No	Have rheumatic fever	Yes	No
Have prolonged bleeding when cut	Yes	No	Have Asthma	Yes	No
Suffer serious illness	Yes	No	Have liver problems	Yes	No
Smoke – how many per day:	Yes	No	Had accident involving the face	Yes	No
High risk of AIDS	Yes	No	Heart related condition (Heart murmur)	Yes	No
Problem with injections	Yes	No	Problem with previous dental treatment	Yes	No
Have epilepsy	Yes	No	Have diabetes? Which type:	Yes	No
Have hepatitis	Yes	No	Currently Pregnant	Yes	No
Recreational drug use	Yes	No	If so, how many months are you:		
Number of standard drinks (if any) consumed per week: Beer: Wine: Spirits:					

If you have circled yes to any of the above, please provide details:
.....
.....

Do you suffer any allergies? ☐ Yes ☐ No
If yes, please state.....
Are you currently taking medication? ☐ Yes ☐ No
If yes, please state

Drug	Strength	Frequency
……	……	……..
……	……	……..
……	……	……..
……	……	……..

e you **l**:

I, the undersigned, agree to be responsible for payment of all services rendered on my behalf of my dependants. I understand that ALL dental services, emergency or otherwise, must be paid for at the time services are performed. Kelmscott Dental Office Staff will assist in processing my health insurance through a Hicaps machine. If the insurance card is not available or valid, I understand that the account will need to be paid in full on the day of the appointment and claimed through insurance at a later date.
I agree to pay all legal and collection charges incurred by the Dentist if I default in paying my dental account by the arranged date. Accounts which are not paid on the date of consult will be issued with a seven (7) day account. A copy of a valid photo ID will be taken by the Office Manager in the event of a seven (7) day account being issued. If this account is not paid within the specified time, interest will be applied at 14% per annum or an administration fee specified by Painless Dental. All costs related to collection of outstanding accounts by a third party, including legal or debt collection costs, will be passed on to the debtor.
I understand that any treatment plan advised by the Dentist is only valid for a period of (6) six months from the date of the patient examination. I understand that the costs are subject to changes after a (6) six month period.
I confirm that the information provided is true and correct at the time of signing.

Signature .....Date.....