MEDICAL HISTORY

blomberg DENTAL
Prosthodontics • Dental Implants • Family Dental Care

Welcome to our practice. The following information is required to enable us to give you our best attention. Each question is relevant to modern dental practice and is confidential.

Title (eg. Mr/Mrs/Dr): _____ Full Name: _____
Date of Birth: _____ Occupation/Employer: _____
Home Phone: _____ Mobile: _____ Business Phone: _____
Email: _____ **Preferred contact method: PHONE SMS EMAIL**
Private Address: _____ Postcode: _____
Postal Address (if different from above): _____ Postcode: _____
Is this your first time with us? (Please circle): Y / N (If yes please answer the next question)
Who should we thank for the referral/recommendation? _____
Contact in case of emergency: _____ Phone: _____

PLEASE PLACE A TICK BESIDE ANY OF THE FOLLOWING CONDITIONS THAT MAY APPLY

- ○ Hepatitis Type A B C D E G
- ○ Gastric Reflux
- ○ Contact with HIV/AIDS
- ○ Asthma
- ○ Diabetes Type 1 or 2?
- ○ Radiation Therapy
- ○ Kidney Disease
- ○ Liver Problems
- ○ Tumour History
- ○ Tuberculosis
- ○ Cholesterol
- ○ Rheumatic Fever
- ○ Thyroid Disease
- ○ Osteoporosis
- ○ Addiction
- ○ Prosthetic Implant (Hip/Knee) Please specify: _____
- ○ Do you smoke? Y / N
- ○ High Blood Pressure
- ○ Depression
- ○ Heart Complaint
- ○ Excessive Bleeding
- ○ Heart Valve Disorder
- ○ Physical Disability
- ○ Cardiac Pacemaker
- ○ Stroke
- ○ Epilepsy

Any other conditions please specify: _____
*Please indicate if you have confidential medical information that you do not wish to write down and would like to talk to the dentist about. Y / N

Please circle the following and specify when answering yes:

Are you Allergic to any drugs or medicines? Y / N : _____
Do you normally require antibiotic cover before dental treatment? (ie. recent history of joint replacement, heart condition or history of Rheumatic Fever?) Y / N : _____
Are you being treated by your doctor at present? Y / N : _____
Please list **ANY** tablets or medicines that you are taking including**: bisphosphonates or blood thinners/Aspirin), including Vitamin Mineral/Herbal Preparation**: _____

Have you been a hospital patient in the last 2 years? Y / N Please provide details: _____

Who is your medical practitioner? _____ Telephone: _____
Ladies, are you, or might you be pregnant? _____ Due Date: _____
Is English your first language? Y / N: _____

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Have you experienced any of the following? Please circle a response:			
Does your jaw click or hurt?	Y / N	Do you feel you grind your teeth?	Y / N
Do you wear a night guard?	Y / N	Have you ever had gum disease?	Y / N
Have you ever had your bite adjusted?	Y / N	Do you think you have bad breath?	Y / N
Do your gums bleed when you brush your teeth?	Y / N	Do you experience sensitivity with Hot/Cold? (Circle which one)	Y / N

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address, and telephone number but it is also necessary for the dentist to obtain from you details regarding your general health and past medical or surgical events. Without this general health picture, the treating dentist is unable to plan your care properly.
Naturally, some of this information is of personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others.
We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- *This information will only be used by the treating dentist in order to deliver your care to the highest standards.*
- *It will not be disclosed to those not associated with your treatment, without your express consent.*
- *You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times.*
- *There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.*
- *Our staff are trained to respect these principles at all times.*
- *We assume that we could disclose relevant information to other practitioners to whom you are referred to in relation to your dental care.*

If you have any questions regarding the information we collect from you and hold in your dental records, please do not hesitate to ask us. We are acting in your interests at all times.

PAYMENT OF FEES AND CONSENT FOR PROFESSIONAL SERVICES

- At the time of consultation/treatment an account will be raised. This account is payable on the day.
- Payment can be made by way of Cash, Cheque, Debit Card, Visa, MasterCard, or American Express. **We do not accept Diners**. All credit cards attract a 1.5% surcharge. We offer direct claiming facilities for health funds.
- For treatment involving any dental laboratory component half of the estimated final fee will be required when final impressions are made.
- **The balance will be due at completion of treatment.**
- I understand and accept these conditions of payment and consent to treatment.
- **Please note: A minimum of 48hours notice will be required for re-scheduling or a cancellation fee will be payable.**

I have completed this form to the best of my knowledge and acknowledge that this represents an accurate medical history. On future visits I will advise the dentist of any changes to the history.

Signed: _____ **Date:** _____
(Parent / Guardian if under 18 years)