MEDICAL HISTORY

FULL NAME ______________________________

DATE OF BIRTH ______________________________

ADDRESS ______________________________

PPSN ______________________________

MEDICAL CARD ______________________________

EXPIRY DATE ______________________________

HOME/MOBILE NO ______________________________

OCCUPATION ______________________________

NAME OF GP ______________________________

EMAIL ADDRESS ______________________________

1)Do you consent to the practice checking with Welfare Partners if you are eligible for cover under P.R.S.I.

Please Highlight YES OR NO

2)Do you consent to the practice contacting you by Phone, SMS or Email regarding your appointments.

YES OR NO

3)Do you consent to the Dentist processing your information and storing it for the purpose of providing you with Dental care & Treatment.

YES OR NO

4)Do you agree to pay for your treatment at the end of each appointment, this will also include if you hold the Medical Card as not all treatment may be covered.

Signature: ______________________________

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Do you attend the Doctor for any specific complaint?

____

Name of any medications/tablets being taken:

Please Highlight

Prosthetic Cardiac Valve	Osteoporosis	Asthma / Bronchitis
Infective Endocarditis	Arthritis	Hay Fever
Heart Attack	Fibromyalgia	Epilepsy
Heart Surgery	Bleeding Disorder	Fits/ Blackouts
Congenital Heart Disease	Stroke	Fainting Attacks
Cardiac Pacemaker Injury	Chorea	Brain Surgery/
Coronary Artery Disease	Hepatitis	Depression
Heart Murmur Problem	HIV	Mental Health
Blood Pressure: High or Low	Liver Disease / Jaundice	Tuberculosis
Rheumatic Fever	Kidney Disease	Creutzfeldt-Jakob
High Cholesterol	Autism-Asperger’s	Chemo/Radiotherapy

Other: ____________________________________

Are you Allergic to: Penicillin or any medications, Latex or any Foods? Other: _________

Do you smoke Yes or No ______?

If Yes How Many ______

How many units of alcohol would you consume weekly ________?

(Yes or No) Please Highlight

Are you diabetic?	Yes	No
If yes, are you insulin dependent?	Yes	No
If yes, What type?	Type1	Type2
If yes, Is your diabetes well controlled?	Yes	No

Do you take, or have you ever taken any of the following medications?

Please Highlight

Aspirin (Blood thinner), Warfarin (Blood thinner), Fosamax (Bones), Steroids
Immunosuppressive Drugs Other: ____________________________________

Are you pregnant Yes No

Do you take the contraceptive pill: Yes No

Signature: ……………………………. **Date:** ……………….