"Shara" 130 Alexandra Parade,
Alexandra Headland Q 4572
Telephone: 5479 5522

CONFIDENTIAL MEDICAL FORM

Please help us to treat you correctly by completing this confidential medical form.

(Dr/ Mr / Mrs / Ms / Miss)

Name in Full: ____________________

Address: ____________________

Postal Address (if different): ____________________

Date of Birth: ____________________

Telephone: (Home) ______________(Work) ______________ (Mobile) ______________

Preferred Contact Number (please circle) Home Work Mobile

Email address: ____________________

Occupation: ____________________

Emergency Contact Person:____________________ Their contact No:____________________

Have you ever had or are suffering from **PLEASE TICK**

		No	Yes	
1	Allergy to anaesthetics	No ☐	Yes ☐	Details ______
2	Allergy to medications	No ☐	Yes ☐	Details ______
3	Any other Allergies	No ☐	Yes ☐	Details ______
4	Heart Complaints	No ☐	Yes ☐	Details ______
5	Rheumatic Fever	No ☐	Yes ☐	Details ______
6	Pacemaker or defibrillator	No ☐	Yes ☐	Details ______
7	Have you had antibiotics for dental treatment before	No ☐	Yes ☐	Details ______
8	Excessive bleeding	No ☐	Yes ☐	Details ______
9	Blood Pressure (high or low)	No ☐	Yes ☐	Details ______
10	Diabetes	No ☐	Yes ☐	Details ______
11	Epilepsy	No ☐	Yes ☐	Details ______
12	Tuberculosis	No ☐	Yes ☐	Details ______
13	Asthma or respiratory condition	No ☐	Yes ☐	Details ______
14	Gastro intestinal disorders	No ☐	Yes ☐	Details ______
15	Stroke	No ☐	Yes ☐	Details ______
16	Hepatitis A B or C	No ☐	Yes ☐	Details ______
17	HIV	No ☐	Yes ☐	Details ______
18	Bone disorders including Osteoporosis	No ☐	Yes ☐	Details ______
19	Are you pregnant/breastfeeding	No ☐	Yes ☐	Details ______
20	Cancer	No ☐	Yes ☐	Details ______
21	Radiation or chemotherapy	No ☐	Yes ☐	Details ______
22	Are you a Smoker	No ☐	Yes ☐	Details ______
23	Any nervous or mental health conditions	No ☐	Yes ☐	Details ______
24	Any previous medical surgery	No ☐	Yes ☐	Details ______
25	Any other medical condition	No ☐	Yes ☐	Details ______

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PLEASE TURN OVER

26 Medications including:

Medication for bones	No ☐	Yes ☐	Details	______________________
Medications to thin the blood	No ☐	Yes ☐	Details	______________________
Steroids	No ☐	Yes ☐	Details	______________________
Any other medications	No ☐	Yes ☐	Details	______________________

____

27 Are you taking any other natural medicines or supplements ______________________________

28 Your general medical doctor's name ______________________________

29 Contact number (if known) ______________________________

30 Are you seeing any other medical specialists

No ☐ Yes ☐ Details ______________________

HOW DID YOU FIND US

Location	☐	Friend (details)	☐	________________
Yellow Pages	☐	Other dentist (who)	☐	________________
Internet	☐	Other (Details)	☐	________________
Family	☐	Sporting Team/club	☐	________________

DENTAL HISTORY

When was your last dental visit? ______________________________

How often do you clean your teeth	Once a day ☐	Twice ☐	More ☐
Do your gums bleed when you clean your teeth		Yes ☐	No ☐
Do you normally see a hygienist		Yes ☐	No ☐
Are you happy with the appearance of your teeth		Yes ☐	No ☐
Are you happy with the colour of your teeth		Yes ☐	No ☐

Please list any other dental concerns ______________________________

____

Are you in a private insurance fund

No ☐ Yes ☐ Which one ______________________

Do you have preferred days and times (circle one or more)

Monday Tuesday Wednesday Thursday Friday

Morning Lunchtime Afternoon Specific times ________________

PRIVACY POLICY

In order to provide you with the highest standard of dental care, our 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 us to obtain from you details regarding your general health and past medical or surgical events. Without this general information we would be hindered in giving you the correct treatment.

A full copy of the way we maintain your privacy is available on our website at www.cjdentistry.com.au/privacy or is available at the reception desk.

Please read and sign below if you give your consent to the following:

I consent to the use of my dental records (eg. dental x-rays, photographs, plaster models etc.) for purposes of consultations, consultations with my orthodontic/ doctor/health professionals, for educational and research purposes, publication in professional journals, or use in professional collateral materials. I do not consent to the use of my specific name, address, or other identifying information without further written consent.

PLEASE BE AWARE FULL PAYMENT IS REQUIRED AT THE TIME OF APPOINTMENT

Signature of patient/guardian ______________________________ Date ______________