CURREY & JORGENSEN
Family and Cosmetic DENTISTRY

"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

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 _____

_____

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)	☐ _____
Publication	☐	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 _____