TOWER DENTAL

# PATIENT HISTORY FORM

**Welcome to Tower Dental**. Please complete the following medical history form. If you have any questions, please feel free to ask any of our friendly staff. All records are private and confidential.

Title: _____ Given Name:_____Surname:_____D.O.B:_____

Gender: **M** or **F** Pronoun/s_____ Ambulance Cover: YES or NO

Address: _____

Suburb: _____Postcode:_____

Home Phone:_____ Mobile Phone:_____

Email:_____

Your Health Fund:_____Member No:_____Reference:_____

Medicare Card No: _____ Ref No: _____

Emergency Contact Person: _____ Phone: _____

Relationship: _____Responsible Person for this Account:_____

## Medical History

Have you been vaccinated against COVID19? **YES** **NO**
Double Dose or Single Done **Double Single** **Booster**

Please tick the appropriate box:

| | | | |
|---|---|---|---|
| No of Smokes (per day) | | Pregnancy or possibly pregnant | |
| Diabetic | | How Many Weeks Pregnant | |
| Bruising or persistent bleeding | | Antibiotic Cover required | |
| Hearing / Sight Impairment *(please circle)* | | Do not recline | |
| Recent hospitalisation | | Hepatitis A, B, C or D (please specify) | |
| Rheumatic Fever | | Thrombosis | |
| High Blood Pressure | | Asthmatic | |
| Low Blood Pressure | | Anaemia | |
| Heart Surgery | | Haemophilia | |
| Pacemaker Fitted | | HIV | |
| Heart Murmur | | Chest Surgery | |
| Bronchitis | | Emphysema | |
| **Other:** | | | |

**Allergies:**

| | | | |
|---|---|---|---|
| Penicillin | | Latex Allergy | |
| Hay Fever | | Medicines | |
| Local Anaesthetic | | Plants | |
| Foods | | Foods | |
| Aspirin | | Other allergy conditions | |

TOWER DENTAL

**List of Medications:**

_____

_____

**GP Information:**

GP Practice:_____Phone:_____

Name of your Doctor: _____

**Dental History:**

When Was Your Last Dental Visit? _____

When Was Your Last Scale and Clean? _____

What is the purpose of your visit here today? _____

**How did you hear about Tower Dental?**_____

**Would you like to receive 6 monthly SMS reminder from us to remind you of when you are next due for your appointment:**

Please select Yes or No:

**Yes** **No**

**Payment Policy**

**It is the policy of Tower Dental that all patients settle their accounts in full after each appointment. We accept cash, credit cards and Eftpos. Health insurance claims can be made electronically at reception. In the event that you forget to bring your health insurance card to your appointment, we will request payment in full. Should this occur it is your responsibility to present your invoice and receipt to your Health Fund for processing/refund.**

I have completed this questionnaire to the best of my knowledge and understand the payment policy. I acknowledge that failure to make a full health disclosure may place me at undue medical risk.

**Name:** _____**Sign:**_____**Date:** ____/____/____

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