Lasting Impressions Dental

Medical History Form

Title ○Dr ○Mr ○Mrs ○Miss ○Ms ○Other

Surname _____ First name _____ Date of birth _____

Preferred name _____

Home address _____

_____ Postcode _____

Postal address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

Email _____

Health fund for dental cover _____ Membership No. _____ Patient ID. _____

Medicare Card No. _____ Veterans' Affairs Card No. _____

Occupation _____

Emergency contact _____ Relationship to patient _____ Contact No. _____

Person responsible for account (must be completed if patient under 16, if same as above please tick here) ☐

Name _____ Relationship to patient _____

Address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

If third party, insurance company/employer responsible for account

Medical Questionnaire - Private and Confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/Current medical conditions:

Are you receiving any medical treatment at present Y ○ N ○ Details _____

Have you had any serious or long standing illness Y ○ N ○ Details _____

Have you ever been hospitalised Y ○ N ○ Details _____

Please indicate if you have EVER had any of the following:

Any heart complaint/treatment	Y ○	N ○	Tuberculosis	Y ○	N ○
Rheumatic fever or heart valve surgery	Y ○	N ○	Any nervous system disorder	Y ○	N ○
High or low blood pressure	Y ○	N ○	Gastric ulcer	Y ○	N ○
Blood Disorders	Y ○	N ○	Asthma/Bronchitis /lung conditions	Y ○	N ○
Anti-coagulant therapy	Y ○	N ○	Radiation therapy/chemotherapy	Y ○	N ○
Joint replacement surgery	Y ○	N ○	Thyroid disease	Y ○	N ○
Osteoporosis or low bone density	Y ○	N ○	Hepatitis, jaundice or liver disease	Y ○	N ○
Epilepsy	Y ○	N ○	Treatment for any form of Cancer	Y ○	N ○
Diabetes	Y ○	N ○	Transplanted organ or bone marrow	Y ○	N ○
HIV	Y ○	N ○	Pregnant (when due) _____	Y ○	N ○
			Other _____		

Do you smoke Y ○ N ○ Social ○

Current medications (prescription, over the counter, herbal)

_____

Allergies Nil known ○ Yes ○ - Details _____

Medical practitioner _____ Suburb _____

I agree that the above is a true and accurate record. I understand that Lasting Impressions Dental requires payment on the day of treatment. Any expenses, costs or disbursements incurred by the Lasting Impression Dental in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

PLEASE NOTE: The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

✗ Signature _____ Date _____

OFFICE USE ONLY.

Form checked by _____ **Form scanned date** _____