MACEDON ST DENTAL GROUP PATIENT HISTORY FORM

In order for this dental practice to provide the highest standard of care, it is requested you fill in this form carefully and thoroughly.

Surname:…………………………………………………………………… **First Name:**…………………………………………………………………….
Title:(Mr/Mrs/Ms/Miss/Other………………………………….. **Date of Birth:**…………………………………………………………………

Home Address:..**Post Code:**……………….
Home Phone:………………………………**Mobile:**…………………………………………………….**(BH) Ph:**.....................................

E-mail:………**Fax:**………………………………….
Emergency Contact:……………………………………………………………………………………………..**Ph:**…………………………………..
Relationship:……………………………**Address:**...**Post Code:**………………

Medical Doctor:……..
Address:……………………………………………………………………………….**Post Code:**………………………………**Ph:**………………
Health Fund (if applicable)…………………………………………**Membership Number:**…………………………**Ref no:**…………
Person responsible for fees:………..

PLEASE CIRLCE YOUR ANSWER TO THE FOLLOWING:

Have you ever had any adverse reaction to any treatment or medication? Yes / No
If yes please give details……….
Do you take Drugs/Medication regularly? Yes / No
If yes please list all……….
Female Patients, are you pregnant? Yes / No

PLEASE TICK IF YOU HAVE/HAD ANY OF THE FOLLOWING:

O High/Low Blood Pressure
O Heart Ailment
O Excessive Bleeding
O Asthma
O Tuberculosis
O Stomach/Bowel probs (ulcer)
O Kidney Disease
O Cancer
O Nervous/Psychiatric condition
O Diabetes
O Thyroid Problem
O Osteoporosis
O Epilepsy
O Hepatitis A,B,C
O Aids/ HIV
O Latex Allergy
O Radiation Therapy
O Lung Disease
O Stroke
O Pacemaker
O Artificial Heart Valve
O Artificial Hip/Knee/Ankle
O Arthritis
O Rheumatic Fever
O Fainting Disorder
O Steroid Therapy
O Blood Disease (anaemia)
O Other………..

REFERRAL INFORMATION:

How did you hear about this clinic? (tick all that apply)
O Seen the practice
O Yellow Pages
O Advertising
O Internet search
O Local Paper
O Referred by someone…………………………………………………………O Other (please specify)………………………………….

CONSENT FOR SERVICES:

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated and I will assume responsibility for the fees associated with those procedures.
I understand that the practice requires 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee may be incurred if I fail to do so.
I am aware that payment is required on the day of treatment.
***Notice to insured patients regarding dental benefits insurance:** Item numbers on our statement represent as accurately as possible the procedures performed, but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures, attract refunds, and the rates of those refunds, are determined by the conditions of the patient's Insurance Policy. We accept no responsibility, to either party, for any decision the Insurer may make regarding the refund of monies to patient.

Signed:..**Date:**…………………………..
Guardian Name (if applicable):……………………………………………………………………………………….
ALL INFORMATION WILL BE TREATED WITH COMPLETE CONFIDENTIALITY