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Boroondara Dental

PATIENT HISTORY FORM

Welcome to Boroondara Dental! In order for us to provide the highest standard of care, we need you to fill in this form carefully. All information will be kept confidential and will only be disclosed upon your consent.

Title: ____ Surname: _____ Given Name: _____ Birth Date: _____

Home Address: _____ E-mail: _____

Home Phone: _____ Mobile: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Health Insurance Provider (If Applicable): _____ Membership No: _____

Occupation: _____ Medical Doctor: _____ Phone: _____

How did you know about us? _____

What is your main dental concern? _____

Have you ever had any of the following? Please circle:

High Blood Pressure Heart Ailment Rheumatic Fever Hepatitis AIDs / HIV

Asthma/Chest/Breathing Problems Tuberculosis Stomach / Bowel Problems Epilepsy

Kidney Disease Diabetes Thyroid Problems Excessive Bleeding/Blood Disorder

Do you have an artificial hip, heart valve or other prosthetic implant? _____

Do you have any other medical conditions? _____

Do you smoke? _____

Are you pregnant? (Females Only) _____

Are you taking any medicines / drugs? (Please List) _____

Do you have any allergies? _____

Have you ever had any problems with dental treatment in the past? _____

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place myself at undue medical risk.

Signed: _____ Date: _____