

Patient History

Please take your time to provide the following information as accurately as possible. Your co-operation assists us in providing the professional service to which you are entitled. The details of your health will assist us in treatment planning.

Personal details

Title: Mr/Mrs/Ms/Miss/Dr Date of Birth:

Surname: Given Name:

Home Address: Suburb: Postcode:

Phone: Mobile: Email:

Your GP: Your Dentist:

Private Health Insurance Provider: Membership No: D.V.A. No:

Medical history

Please indicate if you have or ever have had any of the following:

	Yes	No		Yes	No
High blood pressure	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Heart problems, defects or pacemaker	<input type="radio"/>	<input type="radio"/>	Thyroid problems	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Excessive bleeding or blood disorder	<input type="radio"/>	<input type="radio"/>
Asthma, chest or breathing problems	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>	Hepatitis (Hep B, or Hep C, etc)	<input type="radio"/>	<input type="radio"/>
Stomach or bowel problems or ulcers	<input type="radio"/>	<input type="radio"/>	AIDS/HIV	<input type="radio"/>	<input type="radio"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>
Anxiety or depression	<input type="radio"/>	<input type="radio"/>	Any other contagious disease	<input type="radio"/>	<input type="radio"/>
Do you have any heart valve, hip or other prosthetic implant?				<input type="radio"/>	<input type="radio"/>
Do you have any allergies e.g. penicillin or latex gloves?				<input type="radio"/>	<input type="radio"/>
Please list any medications you are presently taking:				<input type="radio"/>	<input type="radio"/>
Is there any other medical condition that you wish to discuss in private?				<input type="radio"/>	<input type="radio"/>

Denture history

What service do you require today?

How old are your current dentures? Does your jaw ever click or pop?

Do you suffer headaches or facial pain? Are you happy with your current appearance?

Have you had injury to head or neck? What changes are you hoping for?

Please read the **Privacy Consent** on the other side of the form, then print your name, date and sign.

Privacy Consent Form

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Your **Dental Prosthetist (DP)** collects information from you for the primary purpose of providing quality dental health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your dental health care needs. This means we will use the information in the following ways:

- * Administrative purposes in running this Denture Clinic, including billing.
- * Health Fund/Health Insurance Commission requirements.
- * Disclosure to others involved in your dental health care, including treating doctors, dentists or other dental specialists outside this denture clinic practice.

This may occur through referral to a doctor, dentist or dental specialist.

The records of each consultation will be maintained and referred to by your DP in the management of any dental health problem that may arise.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this Denture Clinic has a privacy policy on handling personal patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the dental health treatment and care given to me and potentially place myself at risk.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than as set out above, my further consent must be obtained.

I consent to the handling of my information by this Denture Clinic for the purpose set out above, subject to any limitations on access or disclosure that I notify this Denture Clinic of.

I consent to being included on the recall database of this Denture Clinic, as detailed above.

Patient Name (please print)

Patient Signature **Date**

You are welcome to have a copy of this document. Do you request a copy? Yes No