# Medical History Questionnaire for Thompson Road Dental Services

Welcome to Thompson Road Dental Services. In order to provide you with complete quality care we need to know about your state of health and medical history. In accordance with the Privacy Amendment Act 2000, and the Health Records and Information Privacy Act 2002, all information provided will be treated in strictest confidence and available only to third parties you have consented to. Please complete as accurately as possible. Thank you

## Patient Information:

**Title:** ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master Surname : _____ First Name : _____

Date of Birth : _____ Home Address : _____

Suburb : _____ Postcode : _____ Home Phone : _____ Work Phone :_____

Mobile Phone : _____ Email : _____ Occupation : _____ Health Fund for dental cover : _____

## Person to contact in case of emergency:

Name : _____ Relationship to patient : _____ Contact number : _____

Person responsible for account:. Must be completed if patient is under 16, if same as above please tick here ☐

Name : _____ Relationship to patient : _____

## Past/Current medical conditions:

Information about your medical history is for your dentist only.

| | | | | | |
|---|---|---|---|---|---|
| Heart Attack/Angina | ☐ Yes ☐ No | High blood Pressure | ☐ Yes ☐ No | Radiotherapy | ☐ Yes ☐ No |
| Heart Bypass | ☐ Yes ☐ No | Thyroid Disorder | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Heart murmur | ☐ Yes ☐ No | Bone Disorder | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Heart Valve Problem | ☐ Yes ☐ No | Kidney Disorder | ☐ Yes ☐ No | Smoker | ☐ Yes ☐ No |
| Irregular heart Beat | ☐ Yes ☐ No | Hepatitis, Aids or HIV | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Lung Disorder | ☐ Yes ☐ No | Artificial Joints | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Arthritis | ☐ Yes ☐ No | Are you pregnant | ☐ Yes ☐ No |
| Bleeding Disorders | ☐ Yes ☐ No | Others | ☐ Yes ☐ No | Specify : _____ | |

Allergies : _____ Current Medical Condition : _____

Medical Doctor : _____

- I agree that the above is a true and accurate record
- I understand that Thompson Road Dental Services requires payment on the day of treatment.
- I acknowledge Thompson Road Dental Services requires 24 Hrs notice on cancellations otherwise a fee will be charged to my account.
- I further acknowledge that failure to attend any appointments may also result in a fee &/or a deposit required prior to future appointments being scheduled.
- Any expenses, costs or disbursements incurred by Thompson Road Dental Services recovering any outstanding money including debt collection fees and legal cost shall be paid by the responsible party above.
- Please inform our receptionist if there are other means of payments involved (Teen Dental Vouchers, VEDS and VGDS Vouchers).

Full Name / Signature : _____ Date : _____