HARVIEDENTAL

ABN: 21 107 417 130

MEDICAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide safety for you. The information you provide is confidential and will be handled in accordance with our privacy policy, which is shown on the back of this form.

TITLE (PLEASE CIRCLE) MR/MRS/MS

PATIENT FULL NAME _____ **DATE OF BIRTH** _____

HOME ADDRESS _____ **POSTCODE** _____

MOBILE _____ **WORK PH** _____

EMAIL ADDRESS _____

EMERGENCY CONTACT NAME _____ **CONTACT NUMBER** _____

MEDICAL PRACTIONER_____ **DENTAL HEALTH FUND**_____

Please Circle

I have confidential information I would like to discuss with the dentist	**Yes**	**No**	
Do you require antibiotic cover before dental treatment?	**Yes**	**No**	**If yes, please explain** _____
Have you had any abnormal reactions to anaesthesia?	**Yes**	**No**	**If yes, please explain** _____
Do you smoke?	**Yes**	**No**	**If yes, how often?** _____
Have you returned from overseas travel in the last 10 days?	**Yes**	**No**	**If yes, where?** _____
Have you been hospitalized in the past 12 months?	**Yes**	**No**	**If yes, please explain** _____
Women – Are you pregnant?	**Yes**	**No**	**If yes, number of weeks** _____
Women – Are you taking any oral contraceptives?	**Yes**	**No**	**If yes, give details** _____

Do you have any of the following conditions? If YES, place any relevant details beside each condition

- ☐ **Alzheimer's Disease**
- ☐ **Anaemia**
- ☐ **Arthritis**
- ☐ **Asthma If Yes, List Inhalers**_____
- ☐ **Blood Disease**
- ☐ **Bronchitis/Emphysema**
- ☐ **Cancer**
- ☐ **Congenital Heart Disorder**
- ☐ **Diabetes**
- ☐ **Drug Dependency**
- ☐ **Epilepsy or Seizures**
- ☐ **Excessive Bleeding**
- ☐ **Fainting Spells/Dizziness**
- ☐ **Pain in Jaw Joints**
- ☐ **Prosthetic Implant**
- ☐ **Heart Disorder**
- ☐ **Pacemaker**
- ☐ **Psychiatric Care**
- ☐ **Hepatitis A**
- ☐ **Hepatitis B or C**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **HIV**
- ☐ **Hypoglycemia**
- ☐ **Kidney Disease**
- ☐ **Leukemia**
- ☐ **Liver Disease**
- ☐ **Low Blood Pressure**
- ☐ **Osteoporosis**
- ☐ **Radiation Treatment**
- ☐ **Rheumatic Fever**
- ☐ **Stomach/Intestinal Condition**
- ☐ **Steroid Therapy**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Thyroid Disease**

Are you taking any medications, pills or drugs? (Please Circle) YES / NO
If YES, please list below

MEDICATIONS

Please list any medications you may be taking (including herbal remedies, vitamins, cold/flu treatments, sleeping pills, pain relievers, implants or contraceptives), so we can take appropriate precautions and avoid drug interactions

MEDICATION/DRUG NAME	DOSE	DURATION OF TREATMENT	PURPOSE

ALLERGIES + ADVERSE REACTIONS

Are you allergic to or have any adverse reactions to any of the following?

☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Metal** ☐ **Latex**

☐ **Local Anaesthetics** ☐ **Foods/Preservatives** ☐ **Other**

Please supply more detail below for any of the above allergies or adverse reactions

MEDICATION/DRUG NAME	NATURE OF REACTION	HOW LONG AGO?

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect information can be harmful to myself and/or the dentists' wellbeing. It is my obligation to notify the dental surgery of any changes regarding medical history.

I have read and accept the privacy policy on the following of this form

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SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

Burleigh Heads:

Ph: (07) 5520 2277

Email: receptionbh@harviedental.com

HARVIE DENTAL

Privacy Policy

In order for us to provide you with the highest standard of dental care, this practice is required to gather personal information from you. This information covers details such as your name, address and telephone number, but it is also necessary for the dentist to obtain details from you regarding your general health and past medical or surgical events. Without your health information, the treating dentist is unable to plan your care properly.

We understand that some of this information is very personal and isn't the kind of information that is discussed or disclosed with others. Harvie Dental will keep your personal information safe and confidential.

We value the need to safeguard this information and, in accordance, with the principles laid down in privacy legislation and the guidelines issued by Harvie Dental, we would like to assure you that:

- **This information will only be used by your treating dentist in order to provide the highest standard of care**
- **Your information will not be disclosed to those not associated with your treatment without your consent.**
- **You may seek access to the information held about you and we will provide this access without undue delay**
- **There are no charges made for requesting your information**
- **We will protect this information from misuse or loss and from unauthorized access, modification or disclosure**
- **We will make sure your information is accurate, complete and current**

If you have any questions regarding the information we collect from you, please do not hesitate to ask us as this information is held in your dental records. We will always have your best interest and wellbeing in mind.