MEDICAL HISTORY

Patient Details

Title _____ *Given Name(s)* _____ *Surname* _____

Date of Birth _____

Primary Contact Number _____

Emergency Contact (name and number) _____

Email Address _____

Residential Address Line 1 _____

Suburb and Post Code _____

Private Health

Provider Name _____

Membership Number _____

Medical History

Please tick if you're currently suffering from or have ever had any of the following conditions;

- ☐ Excessive Bleeding
- ☐ Blood Thinners
- ☐ Blood Disorder
- ☐ Bone Disease (osteoporosis)
- ☐ Bisphosphonate Therapy
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Anxiety / Depression
- ☐ Congenital Heart Defect
- ☐ Cardiac Surgery
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Angina
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Neurological Disorder
- ☐ Psychiatric Care
- ☐ Hearing Impairment
- ☐ Thyroid Disorder
- ☐ Immune Deficiency
- ☐ HIV
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Stroke
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Prosthetic Joints
- ☐ Steroid Therapy
- ☐ Reflux
- ☐ Emphysema
- ☐ Asthma

If you have ticked yes to any of the above conditions, please give detail i.e. procedure and year of surgery; _____

Are you pregnant? Yes ☐ No ☐ *If yes, how many weeks?* _____

Do you smoke? Yes ☐ No ☐ *If yes, how many per day?*_____

*Name of GP Surgery*_____

Allergies

Latex ☐ Penicillin ☐ Sulpha Drugs ☐ Iodine ☐

*Please state if other*_____

Medications

Please list all current medications _____

_____

Dental History

When was your last dental visit? (approx.) _____

What are your main concerns? _____

Preferred method of Communication

Email ☐ Telephone ☐ SMS ☐

How did you hear about us?

Google ☐ Facebook ☐ Bupa Store ☐ Word of Mouth ☐ Passing by ☐

Other _____

Privacy Policy and Signature

All personal information collected by Bupa Dental Corporation is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information.
You can view the policy online at https://www.dentalcorp.com.au/australian-privacy-policy/.
By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Signature _____ ***Date*** _____