## MONASH UNIVERSITY HEALTH SERVICE DENTAL CLINIC - PERSONAL INFORMATION

**PATIENT INFORMATION AND MEDICAL HISTORY FORM**

**Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Master** ☐ **Dr** ☐ **Prof** ☐ Do you require an **INTERPRETER** ☐ **Yes** ☐ **No**

**FIRST NAME** _____ **LAST NAME** _____

**DATE OF BIRTH** D ☐ M ☐ Y ☐ **Student/ Staff/ Visitor** **ID Number** ☐

**ADDRESS** _____

**SUBURB/TOWN** _____ **POSTCODE** _____

**HOME PHONE** _____ **MOBILE** _____

*I consent to the use of* ***email and / or sms as a recall service and for appointment reminders*** **Yes** ☐ **No** ☐

**WORK PHONE** _____ **EMAIL** _____ (optional)

### GUARDIANS AND OTHER CONTACT DETAILS

If child, please state **FATHER / MOTHER / GUARDIAN'S NAME** _____

If relevant, **CARER NAME** _____ **PHONE** _____

**EMERGENCY CONTACT NAME** _____

**PHONE** _____ **MOBILE** _____

### OTHER DETAILS

WHO IS **PAYING FOR THIS ACCOUNT?** _____

DO YOU HAVE **PRIVATE HEALTH INSURANCE FOR DENTAL?** ☐ **YES** ☐ **NO** **FUND?** _____

**Is this consultation related to Workcover, work related injury or transport accident?** **Yes** ☐ **No** ☐

**Country of Origin?** _____ **OCCUPATION** _____

**Are you Aboriginal or Torres Strait Islander?** **Yes** ☐ **No** ☐

**Are you of a cultural background other than Australian?** _____

### HOW DID YOU HEAR ABOUT US?

☐ **Family?** _____ ☐ **Personal Recommendation?** _____

☐ **Google** ☐ **MyMonash website** ☐ **University** ☐ **O Week** ☐ **Medibank Private**

☐ **University Health Services** ☐ **Other** _____

**Privacy Policy:** The information set out above is used to provide you with effective and efficient dental services. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You are entitled to access your information at any time and we will keep your information confidential. If necessary, however, we may pass your information on to other health practitioners or debt collection agencies. Our complete Privacy Policy is available at our reception. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly. By signing below you consent to our staff contacting you regarding any matter relevant to your relationship with our practice.

**Terms of Payment:** I accept responsibility for my account and understand that the fee is payable on the day. Should I be unable to pay on the day I understand the payment is due within 30 days; if my account exceeds 30 days I understand an account keeping fee may be incurred. If my account remains overdue and is referred to a debt collection agency or solicitors, I may be held liable for the costs of such collection plus interest. In that event, disclosure of my personal details will be minimised wherever possible. I accept full responsibility for health fund claims and rejections. Any fee incurred by the practice for cheques not accepted by the bank may be passed to me.

**PATIENT SIGNATURE** **DATE**

## MEDICAL HISTORY FORM

**FIRST NAME** **LAST NAME** **DATE OF BIRTH** D ☐ M ☐ Y ☐

*To the best of your knowledge do you have or have you suffered from the following?*

*If possible please provide approximate date of diagnosis and details in the boxes below.* ***Please X all applicable Boxes.***

| | | | |
|---|---|---|---|
| | **HIGH BLOOD PRESSURE** | | **OSTEOPOROSIS** |
| | **STROKE** | | **IMMUNITY PROBLEMS** |
| | **HIGH CHOLESTEROL** | | **PAGET'S DISEASE** |
| | **ARTHRITIS** | | **BACK OR NECK PROBLEMS** |
| | **RESPIRATORY DISORDERS** | | **INFECTIOUS DISEASE** (MRSA/VRE/STD/HIV) |
| | **CARDIAC/HEART DISEASE** | | Are you/Do you think you may be **PREGNANT**? |
| | **ANXIETY** | | If so, how many weeks? |
| | **BROKEN BONES** | | Have you ever had **SURGERY**? Please state the type |
| | **BOWEL PROBLEMS** | | of surgery and approximate year. |
| | **ULCER** | | |
| | **DIGESTIVE PROBLEMS** | | Do you **SMOKE**? If Yes, how many per day? |
| | **MENTAL HEALTH/PSYCHOLOGY ISSUES** | | |
| | **GYNAECOLOGY/WOMEN'S PROBLEMS** | | Do you drink **ALCOHOL**? If Yes, how many drinks per |
| | **HEART DISEASE** | | week? |
| | **DIABETES** | | Do you use **ILLICIT DRUGS**? Please specify. |
| | **CANCER, IF SO, WHERE?** | | |
| | **ASTHMA** | | Do you have any **ALLERGIES**? Please provide details: |
| | **URINARY/KIDNEY PROBLEMS** | | |
| | **NEUROLOGICAL (NERVE) PROBLEMS** | | Any other medical details your dentist should be |
| | **SLEEP DISTURBANCES/APNOEA** | | aware of? |
| | Previous **adverse reaction** to **dental treatment?** | | Previous **adverse reaction** to **medications?** |

## MEDICATIONS

*Many medications may impact upon your oral health or treatment plan.*

*Please indicate & name any medications that you currently take, or have taken recently.*

- ☐ ANTIBIOTICS _____
- ☐ HEART OR BLOOD PRESSURE MEDICATION _____
- ☐ HORMONE REPLACEMENT THERAPY _____
- ☐ DIABETES MEDICATION _____
- ☐ THE CONTRACEPTIVE PILL (may affect blood pressure or clotting & interacts with antibiotics) _____
- ☐ CANCER MEDICATION OR THERAPY _____
- ☐ ARTHRITIS MEDICATION OR CREAMS _____
- ☐ ANTI-INFLAMMATORIES *E.G. Neurofen, Ibuprofen, Voltaren, Aclin* _____
- ☐ ASTHMA MEDICATIONS OR INHALERS _____
- ☐ DIET MEDICATIONS/ DRINKS OR TABLETS _____
- ☐ PAIN KILLERS *E.G. Asprin, Panadol, Codeine* _____
- ☐ BISPHOSPHONATES *E.G.* Didronel, Bonefos, Fosamax, Alendro, Actonel, Skelid, Aredia, Pamisol, Zometa - *circle.*
- ☐ NATURAL THERAPIES _____
- ☐ NICOTINE REPLACEMENT THERAPY _____
- ☐ OTHER MEDICATIONS, PLEASE LIST _____

**Immunisations** (list) *Are you currently up to date with your immunisations:* ☐ **YES** ☐ **NO**

**PATIENT SIGNATURE** **DATE**