Carillon City
DENTAL

CONFIDENTIAL MEDICAL HISTORY FORM

Name (Mr/Mrs/Miss/Ms/Dr)……

Address……

Date of Birth…… Phone (Home)…… Mobile……

Email…… Occupation…… Employer……

Health Fund Name…… Membership number……

How did you hear about us? Google / Facebook / Flyer / Word of Mouth / Other……

What is the name of your GP or specialist?…… When did you last visit a dentist?……

Please list any medications you are currently taking, including over the counter and herbal medicines

……

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

HEART CONDITION	Y / N	TUBERCULOSIS	Y / N
HEART SURGERY	Y / N	DEPRESSION/ANXIETY DISORDER	Y / N
RHEUMATIC FEVER	Y / N	EPILEPSY	Y / N
HIGH/LOW BLOOD PRESSURE	Y / N	THYROID DISEASE	Y / N
ANTICOAGULANT (BLOOD THINNING) MEDICATION	Y / N	ASTHMA	Y / N
HIV OR AIDS	Y / N	GASTRIC ULCER	Y / N
CANCER type:-	Y / N	COLD SORES	Y / N
CHEMO OR RADIOTHERAPY	Y / N	DO YOU SMOKE? (If so how many a day?)	Y / N
EXCESSIVE BLEEDING OR BRUISING	Y / N	DRY MOUTH	Y / N
OSTEOPOROSIS	Y / N	SNORING OR SLEEP APNOEA	Y / N
BISPHOSPHONATE TREATMENT	Y / N	DO YOU GRIND YOUR TEETH?	Y / N
JOINT REPLACEMENT year:-	Y / N	ARE YOU PREGNANT?	Y / N
DIABETES type:-	Y / N	ARE YOU BREASTFEEDING?	Y / N
FAMILY HISTORY OF DIABETES	Y / N	ALLERGIES (list below)	Y / N
HEPATITIS type:-	Y / N		

WOULD YOU LIKE TO DISCUSS ANY OF THE FOLLOWING WITH YOUR DENTIST

☐ TOOTH WHITENING
☐ ORTHODONTICS TREATMENT (BRACES) INCLUDING INVISALIGN
☐ IMPLANTS
☐ ANY OTHER DENTAL TREATMENT

I CONFIRM THAT THIS INFORMATION IS AN ACCURATE REPRESENTATION OF MY MEDICAL HISTORY. I UNDERSTAND THAT ALL INFORMATION WILL BE TREATED WITH PROFESSIONAL CONFIDENTIALITY. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF AND ON BEHALF OF MY DEPENDANTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

PATIENT SIGNATURE…… DATE…… REVIEWED……

(IF UNDER 18 YRS OLD PARENT/GUARDIAN TO SIGN AND COMPLETE BELOW)

PARENT/GUARDIAN…… DATE…… CONTACT No……