GREENWOOD DENTAL
NORTH SYDNEY

# Medical History Questionnaire

103 Miller Street North Sydney 2060 Ph: 9957 2988

Office Only: Dentist: ___
Entered D4W:________

Welcome to Greenwood Dental. In order to provide you with **complete quality care we need to know about your state of health & medical history**. In accordance with the Privacy Amendment Act 2004 & the Health Records & Information Privacy Act 2002, all information provided will be treated in strictest confidence & available only to third parties you have consented to. Please complete accurately.

**Patient Information**
Title Dr / Mr / Mrs / Miss / Ms

Surname____________________________________ First Name_____________________ Date of Birth__/__/__
Address_________________________________________________________________Postcode_________
Postal address____________________________________________________________Postcode_________
Phone (H) ________________________________ (W) ________________________ (M) _____________________
Email_________________________________________________________________________________
Occupation_______________________________________________ Employers Name______________________
Health Fund_____________________________ Member No._________________ Series No. (number near name)__________

Emergency contact_________________________Relationship_________________Phone______________________

How you heard about us? Please help us by giving as much information as possible (please circle)

Website Street Signage Radio Google Health Fund Other _____________________________________________
Patient referral who? _____________________________________________________________________________

**Person responsible for paying account if patient is under 18**
Name_____________________________________ Relationship to Patient_________________________________
Address____________________________________________________Phone_______________ (M) ___________
If third party, insurance company/employer responsible for account
Contact name______________________________________________ Phone_______________ (M)___________
Address___________________________________________________________________Postcode_________

**Past/current medical conditions**
Information about your medical history is for your dentists use only. All treatment Provided at Greenwood Dental is performed by independent dentists

| | No | Yes | | No | Yes |
|---|---|---|---|---|---|
| Anaemia | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Intellectually Disabled | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Irregular Heart Beat | ☐ | ☐ |
| Asthma | ☐ | ☐ | Kidney Disorder | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | Liver Disorder | ☐ | ☐ |
| Blood Transfusion | ☐ | ☐ | Lung Disorder | ☐ | ☐ |
| Cancer | ☐ | ☐ | Lupus | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Pacemaker | ☐ | ☐ |
| Cholesterol | ☐ | ☐ | Physically Disabled | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Radiotherapy | ☐ | ☐ |
| Endocarditis | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Smoker | ☐ | ☐ |
| Gastro Intestinal Disorder | ☐ | ☐ | Stomach Ulcer | ☐ | ☐ |
| Heart Attack/Angina | ☐ | ☐ | Stroke | ☐ | ☐ |
| Heart Bypass | ☐ | ☐ | Thyroid Disorder | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Heart Value Problem | ☐ | ☐ | Are you Pregnant | ☐ | ☐ |
| Others | ☐ | ☐ ▶ | Specify ______________________ | | |

Medical Practitioner ____________________________Suburb________________
Last Visit______________________________________________________________
Last Dental Visit_______________________________________________________

**Current Medication**
**(Prescription, over the counter, herbal)**

**Allergies**
☐ Nil Known
☐ Yes- Details

**Infectious history**
☐ Nil Known
☐ Yes- Details

**Recent Hospitalisation/surgery**
☐ Nil Known
☐ Yes- Details

**Other relevant details**

I agree that the above is a true & accurate record. I understand that this **Greenwood Dental** Centre requires **payment on the day of treatment**. Any expenses, costs or disbursements incurred by the Greenwood Dental Centre in recovering any outstanding monies including **debt collection fee** & legal costs shall be paid by the responsible party above. I further acknowledge that **failure to attend** any appointment **without 24hr notice** may result in a **cancellation fee** or a **deposit being required prior to future appointments**

**Patient Signature: _______________________________________________ __________Date: _________**