Lifetime Dental Care
Private and Confidential

Personal History

TITLE:_____
NAME:_____ D.O.B: _____
ADDRESS:_____ Home Phone:_____
_____ Work Phone: _____
Mobile: _____
Occupation:_____ Email:_____
Whom may we thank for referring you?_____
Private Health Insurance: Fund:_____ Member No: _____
Number you are on the card:_____

Medical History **Please tick.**

1. Have you ever suffered from Rheumatic fever?_____ □ YES □ NO
2. Have you ever had heart trouble or high blood pressure?_____ □ YES □ NO
3. Do you suffer from or have a family history of Diabetes?_____ □ YES □ NO
4. Do you have a Pacemaker?_____ □ YES □ NO
5. Have you ever had Hepatitis? If Yes- Type_____ □ YES □ NO
6. Have you ever had jaundice or liver disease? If Yes –which?_____ □ YES □ NO
7. Have you ever tested positive to HIV or do you now have AIDS?_____ □ YES □ NO
8. Do you have a Thyroid problem?_____ □ YES □ NO
9. Have you ever suffered from Epilepsy?_____ □ YES □ NO
10. Have you ever had – asthma, hay fever, bronchitis ? If Yes –which?_____ □ YES □ NO
11. Have you ever suffered from tuberculosis?_____ □ YES □ NO
12. Have you ever had stomach / gastric ulcers?_____ □ YES □ NO
13. Have you ever had radiation therapy?_____ □ YES □ NO
14. Do you bruise / bleed easily?_____ □ YES □ NO
15. Do you suffer from any blood disorders?_____ □ YES □ NO
16. Have you ever had a joint replacement?_____ If Yes – when?_____ □ YES □ NO
17. Have you been hospitalized or under a doctors care in the past 12 months? □ YES □ NO
18. Please list all medications : _____
    _____
19. Have you ever had a reaction to or are you allergic to any medication, chemical or substance? □ YES □ NO
    If Yes please list;_____
    (EG: penicillin, local anaesthetic, antiseptics, latex chlorine, sulpher)
20. Have you ever been advised to take antibiotics before dental treatment?_____ □ YES □ NO
21. Do you suffer from any other illness?_____ □ YES □ NO
    If yes - which?_____
22. WOMEN : are you possibly pregnant? □ YES □ NO Due Date: _____
23. Do you smoke?_____ □ YES □ NO

In signing this form I acknowledge that this represents an accurate medical history. I will also supply my dentist with any relevant changes to this history as required. All medical information will be treated with complete professional confidentiality.

*Date :*_____ *Signature* _____

Thank you for choosing our office to provide your dental care – this is a PRIVATE dental practice and as such, we request that all patients pay for their treatment at the end of each visit (cash, cheques, credit card) – thank you for abiding by this policy.