

INNISFAIL DENTISTS

HEALTH HISTORY

To ensure we are looking after your needs, please complete the following questionnaire. If you would like to know more about why we collect this information and what we do with it, you can read our privacy policy at www.innisfaildentists.com.au

Surname _____ Title (Mr/Mrs/Miss/Ms/Dr) _____
Given Name/s _____ Gender (please circle) M F
Postal Address _____ Date of Birth ____ / ____ / ____
_____ Home Phone _____
Home Address _____ Work Phone _____
_____ Mobile _____
Email _____
Occupation _____
Emergency Contact Person _____ Phone _____
Doctor's Name _____
Dental Insurance Company (Health fund) _____
Is another member of your family a patient at our office? _____

Have you had any of the following?

	Yes	No
Any heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure (high/low)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to anaesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medications	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to latex	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis: A B C D E	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers (stomach)	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Tumour history	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently taking any drugs or medicines? Yes No
If so please list: _____

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Dental Concerns

Yes No

Is there anything else you would like us to know?

Who was your previous dentist? _____

Are you pregnant? _____ Due Date: _____

How long since your last dental appointment? _____

Referral - How do you know about Innisfail Dentists?

Website Phone book

Street signage Radio advertisement

Or...who can we thank for referring you? _____

Consent for Treatment

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature: _____ Date _____

Patient's Name: _____

Parent/Guardian signature: _____ Relationship to patient _____

**WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE
WE ACCEPT VISA, MASTERCARD, PERSONAL/BANK CHEQUE, EFTPOS AND CASH**

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Dr Christer Lindée
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