



Updated Medical History Questionnaire

Thank you for trusting us again with your dental needs. To ensure we continue to provide the best care we require updated information from time to time. Please complete this form as accurately as possible to assist us in providing the best dental care for you. If you have any questions please do not hesitate to ask one of our staff at reception. All information provided will be treated with complete professional confidentiality.

FULL NAME (Mr, Mrs, Miss, Ms, Dr).....

Details remain the same

ADDRESS:.....

SUBURB:..... POSTCODE:..... DATE OF BIRTH:/...../.....

TELEPHONE: (Home)..... (Work)..... (Mobile).....

EMAIL ADDRESS:

<p>Past / Current Medical Conditions</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 30%;"></th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">Yes</th> </tr> </thead> <tbody> <tr><td>Anaemia</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High Blood Pressure</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Arthritis</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Intellectually Disabled</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Artificial Joints</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Irregular Heartbeat</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> 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Medications (prescription, Over the counter, herbal)</p> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Allergies</p> <p><input type="checkbox"/> Nil Known <input type="checkbox"/> Yes - Details</p> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">Infectious History</p> <p><input type="checkbox"/> Nil Known <input type="checkbox"/> Yes - Details</p> </div> <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;">Recent Hospitalisation / Surgery</p> <p><input type="checkbox"/> Nil Known <input type="checkbox"/> Yes - Details</p> </div>
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I agree that the above is a true and accurate record. I understand that Canberra Dental Care requires payment on the day of treatment. Any expenses, costs or disbursements incurred by Canberra Dental Care in recovering any outstanding monies including debt collection fees and legal costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

SIGNATURE: DATE: / /