Medical History Questionnaire

Newcastle City Dental

Welcome to Newcastle City Dental. In order to provide with total patient care we need to know your complete past and current medical history. In accordance with the Privacy Amendment Act 2004 and the Health Records and Information Privacy Act 2002, all information will be treated with strict confidentiality and only available to third parties you have consented to. Please complete accurately.

Patient Information

Title (Dr/Mr/Mrs/Ms/Master/Miss) _____ Gender (M/F) _____
Surname _____ First Name _____
Preferred Name _____ Date of Birth _____
Address _____ Post Code _____
Phone (Home) _____ (Mobile) _____
Email _____
Occupation _____

Health Insurance Provider _____
Member ID _____ Series Number _____
Medicare ID _____ Series Number _____

How did you hear about us? (Signage/Website/Google/Facebook/Pamphlets/Other) _____
Who referred you to us? (Friend/Patient/Medical Professional) _____

Emergency Contact Name _____ Relationship _____
Phone (Main) _____ (Alternate) _____

Medical History

Medications (Prescription/Supplements)	Allergies

Condition (please circle)			*Condition* (please circle)		
Cardiovascular system	Yes	No	Physical disability	Yes	No
(Heart murmur/valve problem/surgery)	Yes	No	Intellectual disability	Yes	No
(Rheumatic Fever/Infective Endocarditis)	Yes	No	Immune disorder	Yes	No
High blood pressure	Yes	No	Gastro-intestinal system	Yes	No
Bleeding	Yes	No	Renal system	Yes	No
Respiratory system	Yes	No	Liver	Yes	No
Central nervous system	Yes	No	Cancer	Yes	No
(Epilepsy)	Yes	No	(Chemotherapy/Radiation therapy)	Yes	No
Mental health	Yes	No	Pregnant	Yes	No
Diabetes	Yes	No	Medication	Yes	No
Thyroid	Yes	No	Allergies	Yes	No
Infectious disease	Yes	No	Hospital admissions/operations	Yes	No
Musculoskeletal system	Yes	No	Smoking	Yes	No

Medical Practitioner Name _____
Phone _____ Suburb _____
Last medical visit _____
Last dental visit _____

The information provided in this document is true and accurate to the best of my knowledge at the time of signing. I understand that Newcastle City Dental requires payment on the day of treatment.

Signature _____ **Date** _____