wyatt ryan
DENTAL SURGEONS

PATIENT HISTORY SHEET

TITLE: (Mr, Mrs, Miss, Ms, Dr) FIRST NAME: ..... SURNAME : .....

HOME ADDRESS: ..... SUBURB: ..... POSTCODE: .....

HOME NUMBER: ..... MOBILE: .....

WORK NUMBER: ..... DATE OF BIRTH: .....

POSTAL ADDRESS (if different from above): .....

NAME OF PERSON RESPONSIBLE FOR FEES: .....

ADDRESS (if different from above): .....

EMERGENCY CONTACT: ..... RELATIONSHIP: .....

CONTACT NUMBER: .....

MEDICAL DOCTOR: ..... CONTACT NUMBER: .....

ADDRESS: .....

WHO RECOMMENDED THIS PRACTICE TO YOU? .....

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE

If possible, provide approximate date of diagnosis / please specify.

High blood pressure	Kidney disease	Bone Diseases/ Osteoporosis
Heart Ailment	Diabetes	Stomach / bowel problems
Rheumatic fever	Thyroid problems	Hepatitis
Epilepsy	Tuberculosis	AIDS / HIV
Asthma, Chest or breathing problems		Mental health/ Psychological issues
Back / Neck / Jaw problems	Cholesterol	Cancer (if so where)

List any other previous illness / comments: .....

.....

Do you have an artificial hip, heart valve or other prosthetic implant?: Yes / No .....

.....

Problems with previous dental treatment: Yes / No .....

.....

continued over page ...

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Are you presently under medical care for any illness?: Yes / No .....

Are you pregnant? Yes / No ..... Do you have Private Health Insurance? Yes / No .....

Do you smoke? Yes / No ..... If yes, how many per day: ..... Have you ever smoked? Yes / No

Do you drink alcohol? No Daily Weekly Monthly Approximate number of drinks: .....

Please list any allergies: .....

.....

Are you taking any drugs, medicines or tablets? Over the counter ☐ Prescribed ☐ Herbal ☐

Please list: .....

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Privacy policy: We need the information set out above to provide you with effective and efficient dental services. You are entitled to access your information at anytime and we will keep your information confidential, if necessary, however, we may pass your information on to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies.

Terms of payment: I accept responsibility for my account and understand that the fee is payable on the day. Should I be unable to pay on the day I understand the payment is due within 30 days; if my account exceeds 30 days I understand an account keeping fee may be incurred. If my account remains overdue and is referred to a debt collection agency or solicitors, I may be held liable for the cost of such collection plus interest. I accept full responsibility for health fund claims and rejections. Any fees incurred by the practice for cheques not accepted by the bank may be passes to me.

SIGNED: ..... DATE: .....

THANK YOU!