FirstBite PATIENT HISTORY FORM

Date of Birth: DD	MM	YYYY	Title:	Mr	Miss	Ms	Mrs	Mst	Other:

First Name:	Surname:
Address:	Postcode:
Home Phone:	Mobile:
E-mail:	Drivers Licence No:
Occupation:	Business Phone:
Emergency Contact Name & Number:	

MEDICAL HISTORY

Doctor's Name:	Phone:

Have you had any of the following?

Rheumatic Fever	Tuberculosis	Excessive bleeding	Epilepsy	Diabetes	High Blood Pressure
Aids/HIV	Hepatitis A, B, C	Asthma	Kidney Disease	Heart Ailment	

Other Medical Problems:

Are you currently under medical care or taking any medication?	Y N	**If yes,** what?
Are you currently taking osteoporosis medication?	Y N	**If yes,** what?
Are you allergic to any drugs, medicines or latex?	Y N	**If yes,** what?
Have you been hospitalised in the last 5 years?	Y N	**If yes,** what for?
Do you have an artificial hip, heart valve or other prosthetic implants?	Y N	**If yes,** what?

Are you a smoker? Y N **If yes,** are you aware that smoking has adverse effects on skin and bone healing and may compromise any treatment? Y N

WOMEN. Are you pregnant? Y N

DENTAL HISTORY

Have you ever had any problems with dental treatment?	Y N	**If yes,** describe:
Have you had your wisdom teeth removed?	Y N	
Does dental treatment make you nervous?	Y N	
Are you aware of clenching or grinding your teeth, day or night?	Y N	

Please indicate the last time you visited the dentist:

Are you here for: Check Up | Toothache | Appearance | Clean | Other Reasons

Chief complaint about your teeth:

Is there anything about your smile you would like to change?	Y N	**If yes,** what?
Do you have dental insurance?	Y N	**If yes,** which fund?

HOW DID YOU EVER KNOW WE EXISTED? (Tick as many as appropriate)

Recommended by someone

Seen the practice	Visited our website	Web search (Google or Bing)	Social (Facebook or Instagram)
Direct mail or letterbox drop	Newsletter	Email newsletter	Exhibition
Sponsorship		Other	

Are you of Aboriginal and/or Torres Strait Islander origin? Y N

I have completed the above to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk. I also understand that I am fully responsible for the financial aspect of my dental treatment. I have read & understood the FirstBite Dental Privacy Policy.

Signed:

Checked: Date:

Guardian's Name:

P.T.O. FOR PRIVACY POLICY

FirstBite

HEALTH INFORMATION – PRIVACY CONSENT FORM

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988.

Our practice respects your right to privacy. We realize that it is important that you understand the purpose for which we collect details about your health as well as how this information is used at your practice and to whom this information might be disclosed.

The policy of our practice is to follow these procedures.

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name address and health insurance details will be used for the purpose of addressing accounts to you as well as processing payments and writing to you about our services and any issues affecting your treatment.

2. We may need to disclose your health information to other health care professionals or require it from them if, in our judgment, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.

3. We may also use parts of your health information for research purposes in study groups or at seminars as this may provide benefit to other patients. Should that happen your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statuary fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. If any of the information we have about you is inaccurate, you may as ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.