818 Dental

Medical History | Kids

As part of our commitment to provide you with the best possible care & service, we aim to update your medical history regularly. Please take a few moments of your time to complete this form.

Title(Mst/Miss): _____ First Name: _____ Surname: _____

Date of Birth: _____ Parents name: _____

Home Address: _____

Mobile: _____ Phone (Home): _____ (Work): _____

Parents email: _____

We confirm all of our patients appointments – which method do you prefer? SMS / Email / Phone

How did you hear about our practice? (Internet, Facebook, Patient etc) _____

(If you were referred to us by an existing patient please list their name so we can thank them) _____

Do you have Private Health Insurance? YES / NO Health Fund Name _____

Medical History

Have you ever been hospitalised?; If so for what? _____

Are you currently taking any medications? If yes please list name/dosage _____

_____

Are you allergic to anything? Anesthetic/Penicillin/Antibiotics/Other? _____

Please circle if you have any of the conditions listed below:

High blood pressure	Aids or HIV infection	Hepatitis
Heart / Kidney / Liver Disease	Cardiac Pacemaker	Heart Murmur
Stroke	Diabetes	Tuberculosis
Asthma	Cancer	Hip / Knee Replacement

Patient Consent

I certify that I have read and understand the above information. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

Signature of Parent/Guardian **Date**

_____ _____