Medical / Dental History Form

LILLYBROOK DENTAL SURGERY
Lillybrook shopping village 3/118, Old Gympie Road, Kallangur,Queensland-4503
Phone No.(07)38862277

Name: _____ Title: ◯ Dr ◯ Mr ◯ Mrs ◯ Miss ◯ Ms
Surname First Name

Date of Birth: ____ / ____ /_____ Your Occupation: _____

Home Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

E-mail address: _____@_____

Emergency Contact Name: _____ Phone: _____

Medical Doctors Name _____ Phone: _____

Health Fund Provider: _____ Do you have dental extras cover? YES / NO

Medicare Number: _____ Patient # on Card _____ Valid to: _____

Do you have a DVA Card: ◯ YES ◯ NO

Are you Aboriginal or Torres Straight Islander: ◯ YES ◯ NO

How did you hear about us? (please circle) ◯ Referred ◯ Internet Search ◯ Friend/Family ◯ Other

PLEASE CIRCLE AND PROVIDE DETAILS:

1. Are you receiving any medical treatment at present? ◯ YES ◯ NO
   Details: _____
2. Have you been in hospital during the past two years? ◯ YES ◯ NO
   Details: _____
3. Are you currently taking any prescribed or over the counter medication including ibuprofen / aspirin? ◯ YES ◯ NO
   Details: _____
4. Are you **allergic** to any medication, tablets or antibiotics? ◯ YES ◯ NO
   Details: _____
5. Have you had any prosthetic surgery? (e.g. heart valve, stents, knee or hip replacements) ◯ YES ◯ NO
   Details: _____
6. Are you currently pregnant or breastfeeding? (Females Only) ◯ YES ◯ NO
7. Do you smoke? ◯ YES ◯ NO How many per day? _____
8. Do you drink alcohol? ◯ YES ◯ NO Amount per day or week _____
9. Have you ever had or are receiving treatment for cancer? ◯ YES ◯ NO
   Details: _____

Please Turn Over

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DO YOU HAVE OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS?

Please circle YES or NO to each condition.

Heart condition	YES	NO	High blood pressure	YES	NO	Low blood pressure	YES	NO
Steroid therapy	YES	NO	Kidney disease	YES	NO	Prosthetic implant	YES	NO
Rheumatic fever	YES	NO	Excessive bleeding	YES	NO	Cardiac pacemaker	YES	NO
Epilepsy	YES	NO	Stroke	YES	NO	Digestive condition	YES	NO
Asthma	YES	NO	Cancer	YES	NO	Liver Conditions	YES	NO
Diabetes	YES	NO	Tuberculosis	YES	NO	Blood borne virus	YES	NO
Thyroid disease	YES	NO	Lung condition	YES	NO	Bone disease	YES	NO
Depression/Anxiety	YES	NO	Blood disease	YES	NO	Radio/Chemo therapy	YES	NO
Sinus trouble	YES	NO	Bisphosphonate meds	YES	NO	Arthritis	YES	NO
Hep A/B/C	YES	NO	HIV / AIDS	YES	NO	Do you take aspirin?	YES	NO

Please list any allergies you have (e.g latex, gluten, penicillin, etc): _____

Please detail any condition not listed here? _____

Dental History

1. When was your last dental examination carried out?_____
2. Have you ever been diagnosed with or been treated for gum disease? YES NO
3. Are you currently experiencing pain, sensitivity or soreness in the mouth? YES NO

   Details: _____
4. Are you nervous, anxious or ever had a bad experience at a dental visit? YES NO

   Details: _____
5. Are you happy with the function and/ or appearance of your teeth? YES NO

   Details: _____
6. Do you want to discuss or find out more about any of the following:

Please CIRCLE:

☐ Replacement of Missing Teeth ☐ Cosmetic Appearance ☐ Removal of Wisdom Teeth

☐ Tooth Whitening ☐ Bad Breath ☐ Bleeding Gums ☐ Tooth Grinding/Clenching

☐ Replacement of silver fillings ☐ Dentures ☐ Dental Implants ☐ Crooked Teeth

Information we hold about you is strictly confidential and never shared without your explicit consent.

Declaration & Appointment Policy:

I understand that appointments are reserved specifically for me. If I cancel or change without providing at least 24 hours' notice this prevents other patients who require your services from accessing them.

I, _____, have read and understood the above condition of being a patient at this
First name Surname

practice, and agree to pay a cancellation fee of $60 should I cancel without giving 24 hours notice. I acknowledge that the information given on this form is true and accurate to the best of my knowledge.

Patient / Parent / Guardian Signature: _____

Date: ____/____/____