PATIENT MEDICAL HISTORY CONSENT FORM

The following information is requested to enable us to give you our best attention. Each question is relevant to modern dental practice and is confidential.

Name_____

(Indicate yes or no and give details where appropriate)	Y	N	Details
Are you being treated by your doctor at present?	☐	☐	----------
Are you taking any tablets, medicines or drugs at present including natural remedies?	☐	☐	----------
Are you currently or ever taken **BISPHOSPHONATES**?	☐	☐	----------
Have you been a hospital patient in the past 2 years?	☐	☐	----------
Do you require antibiotic cover before dental treatment?	☐	☐	----------
Are you allergic or have reacted to any drug or medicine?	☐	☐	----------
Are you allergic to anything? E.g. Latex, Nickel	☐	☐	----------
Do you smoke?	☐	☐	----------
Females, are you pregnant?	☐	☐	----------

	Y	N		Y	N		Y	N
Heart Complaint	☐	☐	Prosthetic Implant	☐	☐	Hepatitis	☐	☐
Heart Valve Disorder	☐	☐	Diabetes	☐	☐	Cancer Treatment	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Epilepsy	☐	☐	Asthma	☐	☐
Excessive Bleeding	☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐

Any other serious condition or disability _____
Is there any issue regarding this medical history which you wish to discuss in private with your orthodontist:
YES ☐ NO ☐

Do you consent for your medical history, x-rays, photos, treatment history to be shared with other affiliated health professionals e.g. Oral Surgeon, General Dentist including the transferring of your records to another Orthodontic Specialist to continue your treatment. YES ☐ NO ☐

Do you consent to having your photos being utilized for training purposes and marketing tools for the practice inclusive of patient newsletter and Facebook. YES ☐ NO ☐

DECLARATION
I have completed this form to the best of my knowledge and declare this to be an accurate medical history of the above mentioned patient. On future visits I will advise of any changes to the history.

Signature_____ Date_____
(Patient or Parent/Guardian if under 18 years)

PRIVATE HEALTH INSURANCE

Townsville Orthodontic Specialists offers payment plans to all orthodontic patients. Specific information about your Private Health Insurance is required to assist you with your health fund rebates when we structure payment plans.

Please contact your Private Health Insurance Company for the following information and bring this with you to your initial consultation.

1. NAME OF HEALTH INSURANCE COMPANY: _____
2. NAME OF THE LEVEL OF COVER: _____
3. LIFETIME LIMIT: _____
4. YEARLY LIMIT: _____
5. PERCENTAGE OF EACH ACCOUNT PAID BY INSURER: _____
6. ANNIVERSARY DATE: _____