LifeCare Dental
Availability, Ability & Accountability

MEDICAL HISTORY FORM

Personal Details (*Please fill in all areas*)

Title: Mr /Mrs /Miss /Ms /Dr

First Name: _____ Date of Birth: ____ /____/____

Surname:_____ Occupation: _____

Street Address _____ Email: _____

Suburb: _____ Phone (M):_____

State: _____ Postcode:_____ Phone (H):_____

Emergency Contact Name: _____ Phone (W):_____

Emergency Contact Number:_____

Medicare #: _____ Exp: ____/_____

Private Health Fund? YES / NO If yes, which one: **HBF BUPA MBP HCF** or Other: _____

Doctor (GP): _____ Contact Number:_____

Do you have a REGULAR dentist? **YES / NO** Name: _____Suburb:_____

How did you hear about us?

Wildcats / LiveChat / Family / Friend / Google / Radio / Facebook / Instagram/ Whitecoat / Signage / BUPA / HBF / Medibank / LifeCare Staff /Walk By/ Yellow Pages Book / Yellow Pages Online

Other Practice_____ Other (Please Specify): _____

Health History: *Do you have now, or have you ever had, any of the following medical conditions?*

(Please tick any you have or had)

Artificial Joints	☐	Avian Flu	☐	Penicillin Allergy	☐
Angina	☐	Tuberculosis	☐	Codeine Allergy	☐
Anorexia/Bulimia	☐	Measles	☐	Latex Allergy	☐
Asthma	☐	Heart Valve Replacement	☐	Sulphur Allergy	☐
Cancer	☐	Low Blood Pressure	☐	Iodine Allergy	☐
Diabetes: Type 1 / Type 2	☐	Excessive Bleeding	☐	SARS	☐
Epilepsy	☐	Fainting/Dizziness	☐	Stroke	☐
Hepatitis A B C (*please circle*)	☐	Smoking/Tobacco Use	☐	Reflux	☐
High Blood Pressure	☐	Bisphosphonate Therapy	☐	HIV/AIDS	☐
Sinus Problems	☐	Heart Attack/Bypass/Pacemaker *(please circle)*			☐

Ladies, is it possible that you are pregnant? YES / NO / MAYBE If yes/maybe how far along? _____ Months

Do you have any other medical conditions or allergies? _____

Are you currently taking any medication? YES / NO _____

For us to better accommodate individual needs and wants, please answer the following questions.

Do you have any questions about adult braces?	YES	NO
Have you ever had braces or a plate?	YES	NO
Are you happy with the colour of your teeth?	YES	NO
Do your gums bleed when you brush?	YES	NO
Are any of your teeth loose?	YES	NO
Do any of your teeth react to hot or cold?	YES	NO
Are you aware of grinding or clenching your teeth?	YES	NO
Do you have clicking or pain in your jaw joint?	YES	NO
Do you snore or suffer from sleep apnoea?	YES	NO
Have you had your wisdom teeth taken out?	YES	NO
Do you get occasional sore throats, tonsillitis or **bouts of bad breath?**	YES	NO

What is your reason for attending today?

_____

Is there anything you dislike about your teeth?

_____

When was your last dental appointment?

_____

How long has it been since you had dental x rays?

_____

By submitting your details you are consenting to receiving marketing emails from us. To opt out of this service please tick the box provided. ☐

Would you like to learn more about our FREE Dentisure™ Insurance? Y / N

Terms and conditions for the supply of dental services:

1. All treatment will be discussed by the dentist with the patient or patient's guardian if 18 years or younger prior to the provision of the dental services.

2. Radiographs (x rays) may be required to ascertain treatment needs

3. Is this a Compensation Claim? Yes/No If **yes** indicate claim type with an **X** in the box:

□ Criminal Injuries Compensation □ Motor Vehicle Compensation

□ Workers Compensation

3.1 I understand that in the event that my claim is rejected by the relevant authority I will be personally liable for the cost of the provision of the dental services.

3.2 If this is a Workers Compensation Claim, please complete the following details:

Employer: _____ Contact Name: _____

Contact Number: _____

4. A cancellation fee will apply to any appointment cancelled without at least 24 hours' notice.

5. Full payment of your account is required on the day of the treatment.

6. Unpaid accounts will be subject to interest at the rate of 7% p.a., calculated for the period the account is due until the date it is paid.

7. In the event that your account is referred to a debt collection agency and/or law firm, you will be liable for all costs incurred in the recovery of the debt.

Privacy Policy and signature

All personal information collected by Bupa Dental is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information. You can view the policy online at https://www.bupadental.com.au/privacy-policy.html. By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient's Name: _____ Patient's Signature: _____ Date: _____