Diamond Denture Studio

DIAMOND

New Patient History Form

Personal History:

Title:_____

Surname:_____FirstName:_____

Date of Birth:_____

Home Phone:_____ Mobile:_____

Next of Kin Contact Name:_____

Next of Kin Contact Phone Number:_____

Your Address:_____

Suburb:_____

Postcode:_____

Email_____

Occupation:_____

Do you smoke: *Yes* ☐ *NO* ☐

Would you like any help to quit *Yes* ☐ *No* ☐

Doctors Name / Clinic _____ (If Known)

Dentists name / Clinic _____ (If Known)

Do you belong to a private health fund? (circle) yes no

Fund name = _____

Where did you hear about us: Local Paper ☐ Internet ☐ Friend ☐

Yellow pages ☐ Dentist Referral ☐ Advertising in mail box ☐ Other _____

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Medical History

We ask these questions for YOUR health and safety and the health and safety of our staff and patients.
Let me assure you that answering yes to any of the questions WILL NOT result in prejudice or preclude you from any form of treatment

Ever suffered/ suffer from: (Please circle Yes / No responses)

Epilepsy, Fits or seizures (Please Circle)	no	yes	Diabetes (Type?) ____	no	yes
Rheumatic Fever	no	yes	Asthma	no	yes
High blood pressure	no	yes	Prolonged Bleeding	no	yes
Heart conditions (List below)	no	yes	HIV/AIDS (Please Circle)	no	yes
Blood disease	no	yes	Hepatitis (A, B, C) (Circle type)	no	yes
Tuberculosis	no	yes	Thyroid problems	no	yes
Anxiety or depression (Circle)	no	yes	Cancer (Type _____)	no	
Stomach Issues	no	yes	Kidney Disease	no	yes
Allergies (List Below)	no	yes	Bowel Issues	no	yes

Any other contagious Disease no if yes please list _____

Heart Valve, Hip or Prosthetic implants (Please circle) no yes

Are there any other medical details about yourself, that we should know about? Please list condition

_____
_____
_____

Please list any medications in the space below, that you are currently taking and daily dosage.
If unsure now, please bring list to next appointment

_____
_____
_____
_____

Denture History (If applicable)

Reason for VisitToday_____

How old are existing dentures _____

How many sets of dentures have you had _____

What improvements are you hoping for_____

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Diamond Denture Studio

Privacy Consent

We require your consent to collect personal information about you.
Please read this information and sign where indicated below.

We collect information from you for the primary purpose of providing quality dental health care.

We require you to provide us with personal details and full medical history so we may properly assess, diagnose, treat and be proactive in your dental health care needs.

This means we will use the information in the following ways:

***Administrative purposes in running this Denture Studio, including billing.**

***Health Fund / Health Insurance Commission requirements.**

***Disclosure to others involved in your dental health care, including treating doctors, dentists or other dental specialists outside this denture centre practice. This may occur through referral to a doctor, dentist or dental specialist**

I understand that if my information is to be used for any other purposes other than set out above, my further consent must be obtained

I consent to the handling of my information by Diamond Denture Studio for the purpose set out above, subject to any limitations on access or disclosure that I notify this Denture Studio of.

I have read the information above and understand the reasons why this information must be collected. I am also aware that this Denture Studio has a privacy policy on handling personal patient information.

Patient Name:_____

Patient Signature: _____

Date:_____