COUNTRY CARE DENTAL

PATIENT HISTORY FORM
Welcome to Country Care Dental

Name: **(Mr/Mrs/Miss/Ms/Dr)** ______________________________ **Date of Birth:** ____________
Postal Address: ______________________________
Email: ______________________________ **Occupation:** ____________
Contact Number: ____________ **Medicare Number:** ____________
Emergency Contact: ____________ **Relationship:**____________ **Phone:** ____________
Do you have private health insurance with Dental Cover? NO/YES Fund:____________
Are you a Veterans Affairs White or Gold Cardholder? NO/YES Number: ____________
Who can we thank for recommending this practice to you? ____________
How long has it been since your last dental appointment? ____________

Please circle applicable conditions that you have currently or have ever had:

Rheumatic Fever	Yes/No	Hepatitis; A B C D E	Yes/No
Epilepsy	Yes/No	High/Low Blood Pressure	Yes/No
Asthma	Yes/No	Heart Ailment	Yes/No
Tuberculosis	Yes/No	AIDS/HIV	Yes/No
Diabetes: Type 1/Type 2	Yes/No	Excessive bruising or bleeding	Yes/No
Kidney disease	Yes/No	Osteoporosis	Yes/No
Cancer	Yes/No	Other bone conditions	Yes/No
		Endocarditis	Yes/No

Please list any other medical conditions you may have that are not mentioned above:
____

Do you have an artificial hip, heart valve or other prosthetic feature? If yes, when was it placed?
____

Are you presently under medical care or taking any medicines or tablets? YES/NO Please List:
____

Allergies: If any please list the type of allergy (medicine or products etc.)
____

Female patients, are you pregnant? YES/NO Due Date: ____________

Consent for Treatment

I hereby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anaesthetics and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which be incurred as if the debt is collected in full, including legal demand costs.

We sincerely thank you for your assistance and look forward to taking care of you and your family.

Patients Signature ____________ Parent/Guardian (if applicable) ____________ Date: ____________