Medical-Dental History (Confidential)

Dr Bo Jiang & Associates

Patient Information:

Title: _____ First Name(s): _____ Surname: _____
Please write preferred name in brackets

Date of Birth: ____/____/_____
Day Month Year

Address: _____ Home: _____ ☐
Number, Street

_____ Post Code: _____ Work: _____ ☐
Suburb/City

Email: _____ Mobile: _____ ☐
Please tick preferred contact method

Occupation: _____

Medical Doctor's Name: _____ Medical Clinic: _____

Emergency Contact Name: _____ Phone: _____

Do you have or have you ever had any of the following medical conditions? (Please tick/circle those that apply)

Rheumatic Fever		Diabetes Type I/Type II		High Blood Pressure	
Heart Valve Disorder		Radiation Therapy		Low Blood Pressure	
Steroid Therapy (e.g. Cortisone)		Kidney Disease		Heart Murmur	
Epilepsy		Tuberculosis		Excessive Bleeding	
Stroke		Asthma		Cardiac Pacemaker	
Nerve/Muscle Disorder		Bronchitis, or other Lung Ailments		Prosthetic Implant	
Nervous Condition		Stomach/Digestive Condition		Contact with HIV/AIDS Virus	
Thyroid Disease		Leukaemia, other Blood Diseases		Hepatitis, or other Liver Diseases	

If ticked any of the above, please give details if applicable: _____

_____

Please list any other health conditions not mentioned above: _____

_____

Are you under any regular medication? Yes ☐ No ☐ Please list: _____

_____

Do you require antibiotic cover before dental treatment? Yes ☐ No ☐

Do you have any allergies (e.g. food, medications, latex)? If yes, please list: _____

Do you smoke? Yes ☐ No ☐ Past ☐ Please state frequency (e.g. cigarettes per day/week): _____

Ladies, are you pregnant? Yes ☐ No ☐ If yes, please state months: _____

Please list any issues you have with your teeth or mouth: _____

_____

Name of private health insurance fund (if applicable): _____

Veteran Affairs Number (if applicable): _____ Gold/White Card (Please circle)

Would you like us to remind you when your next check-up is due? Yes ☐ No ☐

How did you hear about us? Local/Ads/Phone book/Yellow Page/Internet/Friends (Please circle)

If referred, whom should we thank? _____

Fees: All fees are payable on the day. Direct Health Fund (HICAPS) claim available.

_____ Date: ___/___/_____
Signature of Patient or Guardian

*If the patient is under 18 years of age, the following guardian must sign and is liable for accounts,

Guardian's full name: _____ Date of Birth: ___/___/_____