endodontic group

WELCOME TO OUR PRACTICE

Your medical history can affect the success of your dental treatment and will guide us on how to provide safe treatment for you. The information you provide is completely confidential and will be handled in accordance with our Privacy Policy & Charter of Patient Rights, which can be found on our website.

PATIENT DETAILS

Title (eg Mr, Mrs, Ms, Mx, Dr, Rev) _____ First name _____ Last name _____

Preferred name _____ Date of birth _____ Gender *(please circle)* **M / F / Other**

Address _____ Occupation _____

Suburb _____ State _____ Post code _____

Phone (Home) _____ (Work) _____ (Mob) _____

Email _____

Who referred you to this practice? _____

Emergency contact person Phone number Relationship

_____

Do you have private health fund insurance with dental benefits? **YES / NO** *If yes, which fund:* _____

Are you a DVA (Dept. of Veterans Affairs) Gold Card holder? **YES / NO** DVA card number: _____

CONFIDENTIAL MEDICAL HISTORY

If you would prefer to discuss any particular medical information with the endodontist please ✓ here ☐

Have you or has anyone in your household been advised to self-isolate?	**Y / N**	Have you been diagnosed or had close contact with someone diagnosed with COVID-19 in the past 14 days?	**Y / N**
Have you experienced or had close contact with anyone experiencing a sore throat, fever, cough or respiratory issues in the past 14 days?	**Y / N**	Have you returned from overseas or had close contact with anyone who has returned from overseas in the past 14 days?	**Y / N**
Have you ever had or do you currently have:			
Heart condition - *If yes, which condition?*	**Y / N**	Asthma	**Y / N**
Heart valve problems or pacemaker	**Y / N**	Bleeding disorder	**Y / N**
Rheumatic fever	**Y / N**	Any type of cancer - *If yes, please state:* *> what kind of cancer*	**Y / N**
High blood pressure	**Y / N**	*> what kind of treatment, eg radiation, chemotherapy, immunotherapy*	**Y / N**
Kidney disease/transplant	**Y / N**	Diabetes	**Y / N**
Liver disease/transplant	**Y / N**	Epilepsy	**Y / N**
Hip or joint replacement - *If yes, which type & what year of replacement*	**Y / N**	Any other serious illness or disability - *If yes, which illness/disability*	**Y / N**

Have you ever had hepatitis or been advised you may be a hepatitis carrier? - *If yes, what type?*			**Y / N**
Is there any chance you are at risk of carrying HIV/AIDS?			**Y / N**
Do you carry any other infectious diseases? (eg Herpes simplex, CMV, herpes zoster) - *If yes, which diseases?*			**Y / N**
Are you being treated for any other conditions from other health practitioners? - *If yes, what conditions & treatments?*			**Y / N**
Do you smoke? - *If yes, how many per day and for how many years*	**Y / N**	Do you drink alcohol?	**Y / N**
LADIES Is there a possibility that you are pregnant? – *If yes, how many weeks?*			**Y / N**
Note: *As many medicines may influence the effectiveness of hormonal contraception, please advise your Endodontist if this is relevant in your case.*			

MEDICATIONS

Are you currently taking any medications? **YES / NO**

If YES, *please list any medications you may be taking* (including herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants or contraceptives), so we can take appropriate precautions and avoid drug interactions.

DRUG NAME	DOSE	DURATION OF TREATMENT	PURPOSE

ALLERGIES

Do you have any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. penicillin), medicines, antiseptics, local anaesthetics, preservatives or latex that we should know about? **YES / NO** *If yes, please state:*

DRUG NAME	NATURE OF REACTION	HOW LONG AGO

SIGNED ---------- DATED ----------

Please scan or photograph completed form and email to **brisbane@endodonticgroup.com.au**