PARKVILLE DENTAL SURGERY
Dr. Daniel T. Duong BDSc.(Melb.)
Dental Surgeon

PARKVILLE
DENTAL SURGERY

PATIENT HISTORY FORM
Welcome to our practice

To help us determine your treatment, please answer the following questions as accurately as possible.

Mr/ Mrs/ Ms/ Miss/ Master/ Dr /Prof

Date of Birth ……..……

Surname: …… Given Name…….……..…

Home Address ……..…….. Email ……..……

……..…….…… ……..

P/ Code …… Phone …….. Mobile…….…….....

Postal Address (if not as above) ……....

Name of the Person responsible for fees …….

Address (if not as above) …….

Emergency Contact ……..……...

Medical Doctor ……..…….…….……..…….....

Who recommended this practice for you? ……..

Do you have Dental Insurance? NO □ YES □ Which fund?……...……..

If YES, please provide your insurance number and patient ID number…….

……

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	NO	YES		NO	YES
Rheumatic Fever	□	□	Hepatitis	□	□
High Blood Pressure	□	□	Epilepsy	□	□
Excessive Bleeding	□	□	Tuberculosis	□	□
Heart Ailment	□	□	AIDS / HIV	□	□
Diabetes	□	□	Asthma	□	□
Kidney Disease	□	□	Are you pregnant?	□	□

NEXT

Do you have an artificial hip, heart valve or other prosthetic implant? ……..…..... □ □

Have you ever had problems with dental treatment? …….……..… □ □

Have you ever had any serious illnesses? ……..……..… □ □

Are you currently under medical care? …….…..... □ □

Are you allergic to any medication? ….…….....…. □ □

Please list name of medicine or products you are allergic to ……..……

Please list any medication you are presently taking ……..……..……

What prompted you to see us today? .....

When was the last time you visited a dentist? .....

How frequently do you see a dentist?.....

How would you like to be contacted for your next check-up? SMS/Phone/Letter/Email

YOUR ASSISTANCE IS MUCH APPRECIATED. Please advise us of any changes in the future.

I understand the need to complete the above questions and non-disclosure may place me at undue medical risk.

Signed ……..… Date ……