38 Merindah Road
Baulkham Hills NSW 2153
Tel (02) 9686 7375
Fax (02) 9686 8470
hillsdentist@gmail.com
www.myhillsdentist.com

Health History Form

So that we can ensure we are looking after your needs, please review and complete the following questionnaire:

(Mr/Mrs/Miss/Mx/Dr) and Surname:	First Name:
DOB:	Address (House Number and Street Name):
Home Phone:	Suburb/postcode:
Mobile:	Work Phone:
Email:	Occupation:
Name of person responsible for fees, if not self: Their address:	

Recommended by: _____

Purpose of visit: _____

Private Health Fund for Dental: YES/NO

Have you had/ do you do any of the following?

Clicking Jaw [ ]
Grind your teeth [ ]
Braces/ Orthodontics [ ]
Night Guard [ ]
Gum Disease [ ]
Smoke [ ]
Bite lips/ Cheeks [ ]

Bad Breath [ ]
Bleeding Gums [ ]
Hot/Cold Sensitivity [ ]
Floss tearing between teeth [ ]
Food Jammed between teeth [ ]
Teeth hurt when you bite hard [ ]

38 Merindah Road
Baulkham Hills NSW 2153
Tel (02) 9686 7375
Fax (02) 9686 8470
hillsdentist@gmail.com
www.myhillsdentist.com

Have you had any of the following? (If yes, please mark)

Rheumatic fever	[ ]	Cystic Fibrosis	[ ]	Excessive bruising	[ ]
High Blood pressure	[ ]	Excessive bleeding	[ ]	Epilepsy	[ ]
Heart Surgery	[ ]	Hepatitis A B C D E	[ ]	Cancer _____	[ ]
Pacemaker	[ ]	HIV/ AIDS	[ ]	Artificial joints	[ ]
Heart Murmur	[ ]	Anaemia	[ ]	Other[ ]_____	
Angina	[ ]	Diabetes	[ ]	_____	
Thrombosis	[ ]	Liver or kidney conditions	[ ]	_____	

Allergies: _____

_____

Current Medications: _____

_____

Consent for treatment

[ ] I authorise the dentist to perform all recommended treatment mutually agreed upon by me at the time of treatment and to employ such assistance as required to provide proper care, including but not limited to taking x-rays, photographs, and administering local anaesthetics

[ ] I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants.

(YES/NO) I agree to the use of my photographs for advertising purposes.

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 would be incurred as if the debt is collected in full, including legal demand costs. By signing below, you agree to abide by all My Hills Dentist policies, including our staff treatment policy.

Patient signature:_____

Date:_____

Parent/responsible party's signature: _____

Relationship to patient: _____