CONFIDENTIAL PATIENT HISTORY

Please read and complete this form carefully so we can provide you with the highest standard of care possible. Our practice respects your right to privacy – your health and personal information will be treated with the utmost confidentiality.

TITLE (Mr, Mrs, Ms, Miss) _________ **FULL NAME** ____

ADDRESS ____

PHONE: HOME _______________ **MOBILE** _______________ **WORK**___________________________

DATE OF BIRTH___________________ **OCCUPATION** ____

PRIVATE HEALTH FUND NAME ____

EMERGENCY CONTACT (NAME/RELATIONSHIP) ____

ADDRESS/TELEPHONE ____

PERSON REPSONSIBLE FOR FEES ____

(Payment required on the day your treatment is completed. No payment plans or accounts will be issued.)

MEDICAL HISTORY	YES	NO	Please provide DETAILS and MEDICATIONS for each disorder.
Heart/Vascular Disorder			
Stroke			
Heart Attack			
Floppy heart valves/valve replacement			
Blood Disorder/Bleeding Problems			
Do you take anticoagulants (blood thinners)?			
Do you take medication for osteoporosis?			
Blood Pressure			
Rheumatic Fever			
Diabetes			
Asthma/Respiratory Disease			
Liver Disease			
Kidney Disease			
Arthritis			
Gastrointestinal/Stomach Disease			
Allergy/Hypersensitivity			
Penicillin Allergy			
Other Drug/Latex Allergies			
Epilepsy			
HIV, Hepatitis B, C or Tuberculosis			
Do you Smoke?			
For Women – Pregnant?			
Other Health Issues			

TODAY'S DATE___________________ SIGNATURE______________________________