Banyule Dental
Teeth for life

Updated Medical History Form

Patient Information

- Preferred Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other: _____
- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone: _____
- Email: _____
- Emergency Contact (Name & Phone): _____
- GP Clinic & Contact number: _____

Medical History

Please tick if you have or have had:

☐ Diabetes

☐ Osteoporosis

☐ Arthritis

☐ Prosthetic joint/heart valve - if yes, please specify: _____

☐ High Blood Pressure

☐ Heart Disease / Stroke

☐ Blood Disorder / Excessive Bleeding

☐ Sleep Apnoea / Snoring

☐ Asthma / Lung Issues

☐ Epilepsy

☐ Infectious Diseases

☐ Immunity Problems

☐ Cancer (type): _____

☐ Mental Health Conditions

☐Allergies (e.g., Penicillin, Latex): _____

☐ Other (please specify): _____

☐ Any recent surgery (if yes, please specify): _____

Do you smoke? ☐ Yes ☐ No if yes, how many/day: _____

2/68 Main Street, Greensborough VIC 3088
Ph: 03 9435 2966 Email: Info@banyuledental.com.au

Are you Pregnant (if applicable)? ☐ Yes ☐ No – Weeks: _____

Current Medications: _____

_____

Privacy Statement

We collect your personal and medical information to provide safe and effective dental care. Your data will remain confidential and may only be shared with other healthcare providers if necessary for your treatment or as required by law.

We may also use secure and approved technologies to assist in diagnostics, treatment planning, and administrative support. These tools are used in accordance with applicable privacy laws and are designed to enhance the quality of your care.

☐ **I consent to the use of such technologies as part of my dental care.**

Appointment & Cancellation Policy

1. If you are unable to attend your scheduled appointment, please let us know as soon as possible. For after-hours cancellations, you may leave a voicemail message.
2. If you are running late, please let us know. If you arrive late but within your scheduled time, your appointment may be shortened to avoid delays for other patients.
3. If you miss your appointment entirely or if less than 24 hours' notice is given, a late cancellation fee of $100 may apply.

☐ **I understand payment is due on the day of treatment.**

☐ **I acknowledge and accept the above policy.**

Patient/Guardian's Name: _____

Signature: _____ Date: _____