142 SURREY ROAD, BLACKBURN, VIC 3130
PH (03) 9878 8208 FAX (03) 9877 0437
Email: info@voguedentalstudios.com.au
Website: www.voguedentalstudios.com.au
Facebook:
www.facebook.com/voguedentalstudios
Instagram: @voguedentalstudios

MEDICAL HISTORY FORM

Thank you for joining the Vogue Dental Studios family! To help us meet all your dental health care needs, please complete the following confidential form. If you require any assistance, please reach out to our friendly reception!

Date: ____/____/____
Preferred Title: □ Mr □ Mrs □ Miss □ Ms □ Child
First Name*: _____
Last Name*: _____
Sex: □ Male □ Female □ Other
Date of Birth*: ____/____/____
Driver's License #*: _____
Address*:_____
_____
Suburb*: _____
State: _____ Post Code*: _____
Email Address*:_____
_____

Mobile*: _____
Home: (_____)_____
Work:_____
(**Asterisks indicates mandatory field)*
Do you have Private Health Insurance?
□ Yes □ No
□ Hospital □ Dental
Fund _____
Ref. Number_____
Policy Number _____
Are you eligible for the Child Dental Benefit Schedule (CDBS)? □ Yes □ No
Medicare Card Number: _____REF # _____

Person responsible for the fees?

□ Self □ Other (please provide details)

_____
_____

EMERGENCY Contact

Full Name*: _____
Relationship to Patient*: _____
Email Address*:_____
_____

Mobile*: _____
Home: (_____)_____
Work:_____
(**Asterisks indicates mandatory field*

Personal and Referral Information

Who may we thank for referring you to our practice?
□Another patient/friend □Relative □Website □Google □Facebook □Instagram □Other_____
Name of the person referring you to our practice: _____

Please tick ✓ or circle to indicate if you have had any of the following?

If you would like to discuss these questions in private with the dentists please let us know.

□ High Blood Pressure
□ Diabetes
□ Heart Ailment
□ Thyroid problems
□ Rheumatic fever
□ Excessive bleeding or blood disorders
□ Asthma, chest or breathing problems
□ Epilepsy
□ Stomach or bowel problems
□ Hepatitis
□ Tuberculosis
□ Kidney disease
□ Infectious diseases (present conditions only) e.g. HIV

□ Bone disorders /disease e.g. osteoporosis, pagets
□ Pregnant
If yes, please state how many months: _____
□ Hip, knee or joint replacement
□ Heart valve replacement or pacemaker
□ Immunity problems
□ Sleep apnoea
□ Cancer –
Type_____
When? _____
□ Do you smoke?
_____

Other conditions or illness not mentioned:
_____
_____
List any medications or products you are allergic to (e.g. Penicillin, Latex):_____
_____
Have you previously had:
□ Dermal Fillers
□ Botox/Dysport/Muscle Relaxants?
If so, When?
_____

THANK YOU FOR YOUR COMPLETING THIS FORM AS TRUE AS POSSIBLE

I, _____, **agree to be responsible for all payment of fees and understand that payment is due at the time of the service.** I acknowledge that notes, radiographs (X-rays) or models relating to my treatment may need to be sent to other Dental Practitioners to aid them in my treatment and consent to this. I also give my permission for Vogue Dental Studios to use the above contact details to send me confirmation and appointment reminders.

Signed:..... Date: ...../...../.....