Patient Dentals

Title: Mr Mrs Ms Dr Miss Master Prof Fr (Please circle appropriate title)

Surname: ________________________ First Name: ____________________

Middle Name: ____________________ Known As (if applicable): __________________

Date of Birth: ____________________ Occupation: ___________________

Address: ____

Mobile #: ___________________ Home Phone #: ________________

Email Address (Please print clearly): ___________________ Work Phone #: _______________

Parent/Guardian Name (if applicable) : ____

Private Health Fund: ____________________ Membership #: _______________________

Patient ID #: ____________________ (eg 00, 01, 02 etc)

Medicare #: _________________________ Patient ID #: ______________ (eg 00, 01, 02 etc)

Department of Veteran Affairs Membership #: _____________________________________

Preferred Appointment Reminder: SMS Telephone (please circle preference)

6 Monthly Recalls: SMS Postcard (please circle preference)

How did you hear about our practice? ____

Please Turn Over

Medical/Dental History

Do you have now or have you ever had any of the following medical conditions? (please circle)

Asthma	Bronchitis	Emphysema	Other Lung Diseases
Arthritis	Artificial Joints (Hips/Knees)	Cancer	Chemotherapy
Radiation Therapy	Diabetes	Epilepsy	Heart disease/Disease
Hepatitis	HIV/Aids	High Blood Pressure	Low Blood Pressure
Kidney Disease	Liver Disease	Anaemia	Leukaemia
Other Blood Diseases	Rheumatic Fever	Cardiac Pacemaker	Steriod Therapy
Stroke	Tuberculosis	Excessive Bleeding	Nervous Condition
Osteoporosis	Other Bone Diseases		

Any other conditions: ____

Allergies: ____

Please list any **Medications**: ____

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Have you ever required **Antibiotic Cover** prior to dental treatment? **Y/N**

Have you ever had any abnormal reactions to local or general anaesthesia? **Y/N**

Are you **pregnant**? **Y/N**

Are you a **smoker**? **Y/N**

When was your last dental appointment? ____

Your **Medical Practioner** : ____________________________ Phone Number: _______________

Your/ Parent/ Guardian Signature: ____________________________ Date: ___________

Dentist Signature: ____ Date: ___________