BANK STREET DENTAL

PATIENT DETAILS

CONFIDENTIAL

Welcome to our practice. For our records, and to assist in determining your treatment, please answer the following questions as accurately as possible. The Information you provide is confidential and will be handled in accordance with our privacy policy.

Surname: (Dr/Mr/Mrs/Miss/Ms) ____

Given Name(s): ____

Date of Birth: ______________________

Name of Medical Doctor/Practice: ____

Home Address: ____

____

Phone: (Home) _____________ (Work) _______________ (Mobile) ________________

Email Address: ____

Emergency Contact: _______________________________ Phone: _________________

Private Health Fund? YES / NO (please circle) Fund Name: _________________________

Veteran's Affairs Number if Applicable: ____

How did you hear about us (tick as many as required)?

Social media i.e. Facebook   Google Search   Patient Referral

Medical Referral   Other: ____

What are you hoping to achieve with your treatment?

Pain Management   Cosmetic Treatment   Restorative Treatment

Preventative Treatment

Please inform our receptionist if you do not wish to be placed on our recall system.

How would you like to be contacted for future appointments, treatment planning, recalls etc?

E mail   Telephone   SMS

PLEASE TURN OVER TO COMPLETE MEDICAL HISTORY

BANK STREET DENTAL

MEDICAL DETAILS/HISTORY

Have you ever suffered from any of the following? (Please Circle)

Cancer Treatment (give details) ____

Heart Problems (give details) ____

Low/High Blood Pressure
Heart Murmur
Rheumatic Fever
Stroke / Heart Attack
Asthma
High Cholesterol

Diabetes
Multiple Sclerosis
Kidney Disease
Thyroid Problems
Osteoporosis
Epilepsy

Depression/Anxiety
Tuberculosis
Hepatitis A / B / C
AIDS/HIV
Bleeding Blood Disorder
Do you smoke YES / NO

Are you currently taking any Medications or supplements? YES / NO If Yes, please list:

____

____

Are you allergic to any drugs, medicines or latex? YES / NO If Yes, please give details:

____

Do you have an artificial hip, knee, heart valve or other prosthetic implant? YES / NO If Yes, please provide details: ____

Have you had recent surgery? YES / NO If Yes, please give details: __________________

Are you presently under medical care for any other condition not listed? YES / NO If Yes, please provide details: ____

____

Are you pregnant? YES / NO / MAYBE If Yes, Weeks? ____________________________

Have you ever had any problems with dental treatment? YES / NO If Yes please provide details: ____

Are you nervous about dental treatment? YES / NO

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk.

Signed: ______________________________
Patient/Parent/Guardian (Please circle)

Print Name: ____________________________ Date: ____________________________

THANK YOU!