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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: _____

Home Address: _____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Name of Medical Doctor: _____

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

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 | Diabetes | Depression/Anxiety |
| Heart Murmur | Multiple Sclerosis | Tuberculosis |
| Rheumatic Fever | Kidney Disease | Hepatitis A / B / C |
| Stroke / Heart Attack | Thyroid Problems | AIDS/HIV |
| Asthma | Osteoporosis | Bleeding Blood Disorder |
| High Cholesterol | Epilepsy | 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!