PATIENTS DETAILS – CONFIDENTIAL

Your Medical and Dental History

Providing Dentistry for all ages, our staff is dedicated to your health and smile

As a **NEW/CURRENT** patient we need to get to know you and your medical and dental history to provide you with the highest quality treatment.

Date / /

Surname:..... Given names:..... Title:.....

Date of Birth:..... Email:.....

Address:..... Postcode:.....

Ph:(Home)..... Ph:(Work)..... P :(Mobile).....

PRIVATE HEALTH FUND (Dental):..... How did you hear about us? .....

In case of emergency whom should we contact?

Name:..... Relationship:..... Phone:.....

Who is your General Practitioner?..... Phone:.....

Do you have any allergies? (e.g: Penicillin, Latex, Local anaesthetics, etc)

.....

List all tablets or medicines you are taking at present.

.....

Have you had or are you suffering from any of the following? (Please circle)***YES/NO specify.***

- HEART TROUBLE/SURGERY/STROKE/PACEMAKER YES/NO
- OSTEOPOROSIS YES/NO
- Medication including **INFUSION & TABLETS FOR YOUR BONES** YES/NO
- HIGH BLOOD PRESSURE OR LOW BLOOD PRESSURE YES/NO
- EXCESSIVE OR PROLONG BLEEDING/ANTICOAGULANT YES/NO
- DIABETES YES/NO
- PROSTHETIC IMPLANT/JOINT REPLACEMENT YES/NO
- ARTHRITIS YES/NO
- THYROID DISORDER YES/NO
- HIV/AIDS/HEPATITIS YES/NO
- STOMACH/REFLUX OR DIGESTIVE CONDITION YES/NO
- ASTHMA YES/NO
- LIVER OR KIDNEY DISEASE YES/NO
- ARE YOU OR COULD YOU BE PREGNANT YES/NO
- RADIATION OR CHEMOTHERAPY YES/NO
- SLEEP APNOEA YES/NO
- RHEUMATIC FEVER YES/NO
- OTHER (SPECIFY) YES/NO

I have completed this form to the best of my knowledge, and will inform you at a subsequent appointment if my health status has changed.

Signed:..... **THANK YOU**