Please note that this form will be kept under the strictest confidence and that it is required for our records and for complete pre-treatment evaluation.

Title:

Surname: ……..……..... **First Name**:…….... **Date of Birth**: …. /….. /……...

Address:……

Suburb:…….**Postcode**:……

Telephone (Home):……..……(Work): ...…..…….....…… (Mob):……..

Email:……O**ccupation:** .....

Emergency Contact: .....**Relationship to Patient:** ..... **Contact No**: .....

Are you in a health fund? **If so, which one**?.....

Who referred you?
Friend / relative / dentist / other ……..……....

Practice Name/Dentist:……..... **Telephone/suburb**……...

Chief Complaint:

I am mostly concerned with: _____

Medical History:

Conditions	Y	N	**Conditions**	Y	N
Heart			Diabetes		
Rheumatic Fever			Pregnant		
High Blood Pressure			Kidney Disorders		
Blood/Bleeding Disorders			Osteoporosis/Bone Disease		
Anti-Coagulation Therapy			Hepatitis/Jaundice/Liver disease		
Thyroid Disorders			Asthma/Lung conditions		
Radiation Therapy			Joint Replacement Surgery		
Chemotherapy			Cancer		
Anxiety/Depression			Others		

Current Medications and Drugs (prescriptions, over counter, herbal):

_____

_____

Do you have Any **Allergies**? ☐ No. ☐ Yes - Details_____

Medical Practitioner: _____Suburb:_____

Dental History:

How often you visit your dentist? _____

How often you brush your teeth? _____ How often you floss your teeth? _____

Do you smoke? ☐ No ☐ Yes, and I smoke _____ Cigarettes per day for ____years.

Do you drink alcohol? ☐ No ☐ Yes, and I drink_____

All appointments must be cancelled with excess 24hrs notice, or else a fee may be involved. Please also be advised that acceptable forms of payment are credit card, eftpos and cash.
We aim to be as transparent as possible with our fees – please ask if anything needs clarification.

Signature: _____ **Date**:____/ /_____