PERSONAL DETAILS

Last Name	First Name	Preferred Name
Residential Address		
Postal Address		
Phone: Home	Mobile	Work
Email Address		
Date of Birth	Occupation	
Health Fund	Membership No	H/F No. on card
Do you hold a Pension Card ☐	Health Care Card ☐	Seniors Card ☐

Preferred method for appointment confirmation & recalls SMS ☐ Email ☐ Phone ☐ Letter ☐

Medical Practitioner Name
Medical Practitioner Address and Phone Number
How did you hear about us?
Emergency Contact Name
Emergency Contact Address and Phone Number

MEDICAL DETAILS

Do you have or have had any of the following?	YES	NO		YES	NO
Allergies or Reactions to anything	☐	☐	Kidney or Liver Impairment	☐	☐
Local Anaesthetic Problems	☐	☐	Psychiatric Treatment	☐	☐
High Blood Pressure	☐	☐	Cancer and/or Tumour	☐	☐
Prosthetic Heart Valve	☐	☐	Chemo and/or Radiation Therapy	☐	☐
Problems with your Heart			Stroke and or Cerebrovascular	☐	☐
or Cardiovascular System	☐	☐	Sinus Trouble	☐	☐
Heart Attack	☐	☐	Thyroid Trouble	☐	☐
Angina	☐	☐	Arthritis	☐	☐
Pacemaker	☐	☐	Asthma	☐	☐
Prosthetic Joints	☐	☐	Anaemia	☐	☐
Rheumatic Fever	☐	☐	HIV	☐	☐
Hepatitis A B or C	☐	☐	Osteoporosis	☐	☐
Tuberculosis	☐	☐	Have you ever been prescribed		
Diabetes	☐	☐	Bisphosphonates?	☐	☐
Epilepsy	☐	☐	Other	☐	☐

Are you Pregnant? (if so, due date?)

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE GIVE DETAILS

Please list all Medications including non prescription medications

DENTAL HISTORY

Why did you come to the dentist today?	
Are you happy with the appearance of your smile?	
Describe your dental health:	When was your last dental visit?
Are you currently in pain?	Yes ☐ No ☐
Have you ever had a problem with dental work?	Yes ☐ No ☐
Have you ever experienced pain in your jaw or joint (TMJ)?	Yes ☐ No ☐
Do you have Nitrous Oxide during dental treatment?	Yes ☐ No ☐

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorise the dental staff to perform any necessary dental services with my informed consent that I may need during diagnoses and treatment.

Signature	Date

Thank you for tacking the time to fill out this form. Our office is committed to meeting or exceeding the standards of infection control advocated by the Australian Dental Association.