

Mr / Mrs / Ms / Miss / Master / Dr / Other _____ Home phone: _____

Full name: _____ Mobile: _____

Preferred name: _____ Health fund name: _____

Date of birth: _____ Health fund card no: _____

Address: _____ Health fund reference no: _____

Suburb & postcode: _____ Medicare card no: _____

Email address: _____ Medicare reference no: _____

Emergency contact name: _____ Doctor/GP name: _____

Emergency contact no: _____ Doctor/GP phone no: _____

Why have you come to the dentist? _____

How did you find out about us? Who referred you? _____

CONFIDENTIAL MEDICAL INFORMATION:

Are you currently under the care of a physician/specialist? **YES** **NO**

If YES, what is the condition being treated? _____

Are you taking any drugs or medication? Prescribed or recreational? **YES** **NO**

If YES, please list: _____

Do you have any allergies or reactions to drugs? **YES** **NO**

If YES, please list: _____

Have you had any trouble with previous dental treatment? **YES** **NO**

If YES, please explain: _____

Have you had any major surgery? **YES** **NO**

If YES, please list: _____

Please tick below those that apply:

<u>Medical questions:</u>		<u>General questions:</u>
<input type="radio"/> High blood pressure	<input type="radio"/> Sinus problems	<input type="radio"/> Disability (physical or mental)
<input type="radio"/> Asthma	<input type="radio"/> Hepatitis A / B	<input type="radio"/> Aboriginal / Torres Strait Islander
<input type="radio"/> Heart disease/valve/pacemaker	<input type="radio"/> HIV	<input type="radio"/> Diverse background
<input type="radio"/> Cancer _____	<input type="radio"/> Bleeding disorder	<input type="radio"/> Numeracy, literary or language difficulties
<input type="radio"/> Osteoporosis (incl injection)	<input type="radio"/> Smoker / vape	<input type="radio"/> Low socio economic circumstances
<input type="radio"/> Diabetes	<input type="radio"/> Pregnancy _____	<input type="radio"/> Travelling from a rural/remote area

Additional health or general information? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be potentially dangerous to my (or patient's) health. It is my responsibility to inform the dentist of any changes in medical status.

CANCELLATION POLICY: I also acknowledge that appointments cancelled without 24hr notice may incur a \$105 fee.

SIGNED: _____ **DATE:** _____