DENTAL CARE PROFESSIONALS

All details provided will be treated with complete professional confidentiality.

PERSONAL DETAILS

SURNAME	TITLE	GIVEN NAME
PREFERRED NAME	DATE OF BIRTH / /	OCCUPATION
ADDRESS		SUBURB
POSTCODE	EMAIL ADDRESS	
MOBILE No	Other contact No	
PRIVATE HEALTH FUND-dental extras (yes or no)		Fund Name

PREFERENCE FOR APPOINTMENT CONFIRMATION (please circle):	SMS	Email	Telephone	Do Not Confirm

NEXT OF KIN / EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE

MEDICAL HISTORY

Have you had or are you suffering from any of the following? (Please tick all that apply)

☐ Heart / Vascular Disorder *(specify)*_____
☐ Blood Disease / Bleeder *(specify)*_____
☐ Blood Pressure Problem *(specify)*_____
☐ Any Heart Condition *(specify)*_____
☐ Bone Disease (Pagets)
☐ Osteoporosis
☐ Cancer *(specify)*_____
☐ Arthritis
☐ Diabetes *(type)*_____
☐ Are you or could you be pregnant ?
☐ Asthma
☐ Sleep Apnoea
☐ Reflux
☐ Joint Replacement *(specify joint & when)*_____
_____
☐ Recent Surgery or Other Condition *(please note)*
_____
☐ Current Vaper *(frequency?)*_____
☐ Current Smoker *(how many per day?)*_____
☐ Previous Smoker *(when did you quit?)*_____
☐ Any medications please list:_____
_____
_____

Who is your GP or Clinic?	Phone
List any Allergies- E.g.: Local Anaesthetic, Latex, Penicillin, Peanuts, etc *(please specify)* _____	

Patient Signature_____ Date_____