Personal Medical and Dental Information

Dapto Dentists
Quality Meets Affordability

Title:	Surname:	First Name:	Date of birth:
Address:			
Suburb:	Post Code:		Home phone:
Email:			Mobile No:
Occupation:			Work No:
Emergency contact: (Name & relationship)			Contact No:

Private Health Insurance

Provider:	Member No:	Patient No on card:

How would you like to be reminded about your 6 monthly routine check-up? ☐ Letter ☐ SMS

How did you hear about us? ☐ Friends/Family ☐ Flyer ☐ Signage ☐ Facebook ☐ Bus shelter ad

☐ Health fund ☐ News Paper ☐ School Newsletter ☐ Website ☐ Google ☐ Other: _____________

Medical History*

Your Doctor's(GP) Name:	Suburb:	Telephone:

Have you ever had or are you having any of the following condition/s (Please tick):

☐ Asthma/COPD	☐ Diabetes	☐ Epilepsy
☐ Joint Prosthesis	☐ Infective Endocarditis	☐ Rheumatic Fever
☐ Stroke	☐ Congenital Heart Disease	☐ Bleeding Disorder
☐ High Blood Pressure	☐ Heart Murmur	☐ Heart Attack/Angina
☐ Heart Pacemaker	☐ Prosthetic Heart Valve	☐ Cardiac Transplant
☐ Thyroid/Adrenal disorder	☐ Kidney Disease	☐ Liver Disease
☐ Tuberculosis	☐ HIV	☐ Hepatitis A/B/C

☐ Yes ☐ No Are you on any anti-coagulant therapy?
☐ Yes ☐ No Are you on oral/IV bisphosphonates?
☐ Yes ☐ No Are you undergoing Radiotherapy or Chemotherapy?
☐ Yes ☐ No Are you Pregnant or is there a possibility that you may be Pregnant?
☐ Yes ☐ No Do you Smoke?

Other illness or conditions (Please specify):

Previous Surgery (Please specify):

List any medications:

Any Allergies? ☐ Yes ☐ No ☐ Penicillin ☐ Latex ☐ Other (Please specify): ______________________________
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Dental History

Previous dental examination: ______________________ Purpose of your appointment: _________________________

The information provided is true to best of my knowledge. I understand that failure to make full disclosure of my medical condition may place me at undue medical risk and may compromise my dental treatment.

Patient/Guardian Signature____ **Date:** _______________________