

WELCOME TO OUR PRACTICE. PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE.

### Patient Details

|                                      |                                                                                                |
|--------------------------------------|------------------------------------------------------------------------------------------------|
| Title (Mr/Mrs/Miss/Ms/Dr/Other):     | Mobile:                                                                                        |
| Given Name:                          | Home Number:                                                                                   |
| Surname:                             | Email:                                                                                         |
| Preferred Name:                      | Emergency Contact Name:                                                                        |
| Date of Birth:                       | Emergency Contact Number:                                                                      |
| Address:                             | Emg Contact Relationship:                                                                      |
| Suburb:                              | Are you Aboriginal or Torres Strait Islander Origin? Y N                                       |
| Postcode: State:                     | Interpreter or Assistance during treatment? Y N                                                |
| Private Health Fund:                 | Please select preferred method of communication:                                               |
| Occupation:                          | Telephone <input type="checkbox"/> SMS <input type="checkbox"/> Email <input type="checkbox"/> |
| How did you hear about our practice? |                                                                                                |

### Medical History: *Please complete fully,*

|                                              |  |
|----------------------------------------------|--|
| Name of your Medical Practitioner / Practice |  |
|----------------------------------------------|--|

PLEASE INDICATE IF YOU HAVE HAD OR ARE BEING TREATED FOR ANY OF THE FOLLOWING:

|                                       |  |
|---------------------------------------|--|
| Heart Condition / Heart Surgery       |  |
| Heart Valve / Pacemaker               |  |
| Heart Attack                          |  |
| Rheumatic Heart Disease               |  |
| Angina                                |  |
| Anti-coagulant (blood thinning)       |  |
| Abnormal Bleeding                     |  |
| Asthma                                |  |
| Blood Pressure <b>LOW</b>             |  |
| Blood Pressure <b>HIGH</b>            |  |
| Blood Borne Virus (AIDS,HIV, Hep B/C) |  |
| Cancer                                |  |
| Radiation / Chemotherapy              |  |
| Diabetes                              |  |

|                                                            |  |
|------------------------------------------------------------|--|
| Anxiety / Depression                                       |  |
| Epilepsy                                                   |  |
| Joint/Organ Replacement                                    |  |
| Osteoporosis                                               |  |
| Pregnant? Due Date:                                        |  |
| Sinus Trouble                                              |  |
| Snoring / Sleep Apnoea                                     |  |
| Stroke                                                     |  |
| Thyroid Disease                                            |  |
| OTHER                                                      |  |
| If you have answered YES or OTHER, please provide details: |  |

| Dental Allergies / Sensitivities |  |
|----------------------------------|--|
| Penicillin                       |  |
| Adrenaline                       |  |
| Latex                            |  |
| Codeine                          |  |
| Chlorhexidine                    |  |
| Iodine                           |  |
| Sulpha Drugs                     |  |
| OTHER Allergies:                 |  |
| Are you a Smoker?                |  |
| If Yes, how many per day?        |  |
| Are you a Vaper?                 |  |

Are you taking any medication or supplements?

We ask this so your treating dental practitioner can take precautions to minimise risks and known negative interactions.

YES ☐ NO ☐ If yes, please list medications below

|  |
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|  |
|--|

### Additional Support & Needs:

To help us provide safe and appropriate care, please indicate below if any of the following apply to you:

|                                                                       |                                                   |
|-----------------------------------------------------------------------|---------------------------------------------------|
| Interpreter required / preferred language:                            | Support person / carer required                   |
| Assistance with communication, mobility, hearing, or vision           | Alcohol or drug dependence affecting treatment    |
| Cultural or personal considerations relevant to care                  | Difficulty understanding health information/forms |
| Physical, mental health, memory, or cognitive concerns affecting care | Additional info:                                  |

In signing this form I acknowledge that this represents an accurate medical history. I understand that all medical details will be treated with complete professional confidentiality. **Payment Terms:** All accounts are payable COD. Costs, debt collection and legal fees will be incurred and added to all outstanding accounts. I acknowledge that I am the person responsible for paying this account and agree to the above terms and conditions.

Signed.....  
(Patient/parent or guardian if under 18 years)

Date.....