THE DENTISTRY
Macquarie St.

PRE TREATMENT DETAILS FORM

PLEASE COMPLETE ALL DETAILS IN FULL

Title _____ First name _____ Surname _____

Preferred name _____ Date of Birth _____/_____/_____ Health Fund _____

Address _____ Suburb _____

Postcode _____ Occupation _____ Phone (H) _____

Phone (M) _____ Email_____

How did you find us?/Who referred you to our practice? _____

Do you require a translator? _____ Do you have a hearing impairment?_____

Emergency contact (Name) _____ Phone _____

GP's Name _____ Phone _____

Please answer all questions by drawing a circle around your answer e.g: (Y) / N

Do you require antibiotic cover prior to dental treatment? Y / N

If yes, please explain why: _____

Have you had any abormal reactions to local or general anaesthesia? Y / N

If yes, please provide details: _____

Do you smoke on a regular basis? Y / N

Are you pregnant? If so how many months? _____ Y / N

Have you been hospitalised in the last year? If so, why? _____ Y / N

Are you being treated by a medical specialist at present? Y / N

If so, please provide Dr's details _____

Are currently taking any medication? If yes, please provide medication details below: Y / N

_____

Please list any medication allergies or intollerances *(especially penicillin)*:

_____

Please list any other known allergies below *(inc. latex, foods, nickel, preservatives)*:

_____

Have you ever had a difficult tooth extraction? Y / N

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DO YOU HAVE / HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Asthma	Y	/ N	Prosthetic Implant *(e.g. Artificial Hip)*	Y	/ N
Diabetes	Y	/ N	Stroke	Y	/ N
Epilepsy	Y	/ N	Cancer	Y	/ N
Tuberculosis	Y	/ N	High / Low Blood pressure *(specify)*	Y	/ N
Excessive Bleeding	Y	/ N	Stomach/Digestive Condition	Y	/ N
Heart Disorder/condition	Y	/ N	Bone Disease *(inc. osteoporosis)*	Y	/ N
Thyroid Disease	Y	/ N	Anaemia	Y	/ N
Blood Transfusion	Y	/ N	Leukaemia or other disease of the blood	Y	/ N
Cardiac Pacemaker	Y	/ N	HIV	Y	/ N
Steroid Therapy	Y	/ N	Mental Health Condition	Y	/ N
Kidney Disease	Y	/ N	Rheumatic Fever	Y	/ N
Radiation Therapy	Y	/ N	Bronchitis, Emphysema, Lung disease	Y	/ N
Anaphylaxis	Y	/ N	Communicable Disease *(e.g Covid19,Measles)*	Y	/ N

If you answered YES to any of the above, or have any other condition, please provide details below:

_____

_____

Do you have anything you wish to discuss regarding your teeth and mouth? If so, please specify:

_____

_____

Please list any other concerns *(Anxiety, financial concerns, time constraints / travel etc.)* :

_____

_____

I have read and accept the privacy policy ☐ *mark box with* **X**

(Our Privacy Policy can be found on the back of this clipboard / attached to this email. Please inform reception if you would like your own copy)

Patient Signature / Guardian or Carer signature if patient is unable to sign or is under 18 years of age:

_____ Date: _____/ _____/ _____