dental ON FALCONER

MEDICAL & DENTAL HISTORY FORM

PERSONAL DETAILS

It is important to know details about your medical history, as these could affect the success of your dental treatment. The information you provide is confidential and will be handled in accordance with our privacy policy.

Last Name:_____

First Name/s:_____

Title:_____ Preferred Name:_____D.O.B:_____/_____/____

Home Address:_____

Suburb:_____ State:_____ Postcode:_____

Home Phone No._____ Mobile No._____

Email:_____ Private Health Fund:_____

Occupation:_____ Work Phone No.:_____

Emergency Contact:_____Relationship:_____

Emergency Contact Phone:_____

How did you hear about us? □ Yellow Pages □ Website □ Health Fund □ Street Sign

□ Patient/Friend – Name:_____

□ Other_____

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

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Heart Conditions			Diabetes (Type 1 or 2)			Liver Disease or Hepatitis (A, B or C) If yes, please specify:		
High/Low Blood Pressure If yes please specify:			Acid Reflux (GORD)			HIV/AIDS		

Any other conditions/surgeries:_____

_____

PLEASE TURN OVER PAGE

MEDICAL HISTORY DETAILS

Please answer the following questions to the best of your ability	**Yes**	**No**	**Details/Please Specify**
Are you currently taking any tablets or **MEDICATIONS?** (prescribed or over the counter)?			_____ _____
Do you have any **ALLERGIES?** (Eg. Medications, Latex)			_____
Do you have any abnormal reactions to **ANY** medications including local anaesthetic?			_____
Are you taking any **BLOOD THINNING** medications or do you suffer from **EXCESSIVE BLEEDING?**			_____
Have you **EVER** had Cancer? If so please specify.			_____
What treatment did you receive? (Eg. Chemotherapy, Radiation, Surgery)			_____
Do you have **OSTEOPOROSIS**?			
Have you **EVER** had **ANY** medications (including injections) for Osteoporosis or to prevent bone loss? (Eg: Fosamax, Prolia)			_____
Do you have any **HEART VALVE DISORDERS?**			
Do you normally require **ANTIBIOTIC COVER** before dental treatment?			
Are you being treated by a doctor at present?			_____
Do you smoke?			Daily Quantity:
Are you pregnant? (females only)			No. Of Weeks:

When was the last time you saw a Dentist?_____

Signature:_____**Date:**_____

*** PAYMENT FOR DENTAL TREATMENT IS REQUIRED AT THE COMPLETION OF EACH APPOINTMENT ***