EDENS LANDING DENTAL

In order to provide you with the highest standard of dental care, we are required to collect personal information from you. This includes details of your general health and past medical and surgical events. Your privacy is important to us. All the information provided will remain confidential.

Title: _____First Name:_____ Surname: _____

Preferred name:_____ Date of Birth:_____Occupation:_____

Address: _____

Suburb: _____Postcode: _____

Mobile:_____Tel (H): _____ Tel (W): _____

Dental Health Fund: _____ Email:_____

(Parent / Guardian / Spouse / Next of Kin)'s Name: _____Contact Tel: _____

How did you hear about us? ☐ Facebook ☐ Google ☐ Medical Centre ☐ Leaflet ☐ Walk-in ☐ Signage

☐ Referred by family / friends Name: _____ ☐ Other: _____

What is the reason for your visit today?

☐ Comprehensive oral examination, necessary x-rays, ultrasonic scale, removal of stains & fluoride ☐ Broken tooth/filling

☐ Emergency dental treatment / toothache Other concerns:_____

Are you happy with your smile? Not at all It's OK Yes, I am

Who was your last dentist and when did you last see them? _____

MEDICAL HISTORY

Tick 'Y' if applicable

	Y		Y		Y
Hepatitis- Which type?		Endocarditis		Kidney Disease	
HIV/AIDS		Osteoporosis		Liver Disease	
Heart murmur		Allergic to Latex		Reflux / GORD	
Heart Valve Disorder		Tuberculosis		Cancer	
High Blood Pressure		Blood Disorder / Excessive Bleeding		Arthritis	
Heart disease		Asthma		Thyroid Disease	
Rheumatic Fever		Depression / Anxiety		Epilepsy	
Prosthetic Heart valve – When?		Prosthetic Joints – When?		Diabetes – Which type?	

Are you a smoker? Y/N: If 'Yes', how many cigarettes per day? _____ How many years?_____

Who is your medical practitioner and their phone number? _____

Please list any drug / medicine that you are currently taking: _____

Have you had any operation, or been hospitalised in the past 5 years? _____

Do you have any allergy or unusual reaction to any drug/medicine/latex? _____

Do you require antibiotic cover for dental treatment? / Do you have any conditions not listed above?

_____

Ladies, are you pregnant? If yes then how many months?_____

On a scale of 1-10 how would you describe your level of anxiety about your visit today?

Least anxious ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Most anxious

I acknowledge that this represents an accurate medical history.
On future visits, I will advise the dentist of any changes to this.

Patient's Signature _____ Date _____

(Parent/ Guardian if under 18 years)