PERSONAL DETAILS

Name..Date of Birth..
Postal Address..
Phone: home-.. work-.. mobile-..
Email..Private Health Fund.................................
Occupation (optional).. Family Doctor...
Emergency Contact: Name ....Phone...
New Patients – Who can we thank for referring you to our practice...
List any specific dental concerns you would like to address..

....

MEDICAL HISTORY

Have you ever had any of the following

Condition		YES / NO
Heart (surgery, disease, attack, murmur)		YES / NO
Rheumatic Fever		YES / NO
Artificial Heart Valve		YES / NO
Mitral Valve Prolapse		YES / NO
Diabetes	Type **1** or **2**	YES / NO
Asthma		YES / NO
Cortisone / Steroid Medicine		YES / NO
Hepatitis A, B, C, HIV/AIDS (circle)		YES / NO
Artificial Joints or Reconstruction		YES / NO
Are you a smoker:	Current / Past / Never	
Anxiety		YES / NO
Blood Pressure	HIGH / LOW	YES / NO
Heart Pacemaker		YES / NO
Excessive Bleeding		YES / NO
Arthritis / Rheumatism		YES / NO
Tumours		YES / NO
Convulsions / Strokes / Epilepsy		YES / NO
Chemotherapy / Radiotherapy		YES / NO
Blood transfusion		YES/ NO
Females, could you be pregnant		YES/NO

NOTES..

....

- Have you been treated for any condition by a doctor in the last 2 years YES / NO

If yes, what condition (include any surgery)..

....

- Do you have any allergies (ie penicillin, latex) YES / NO

If so, what...

- Do you or have you had any disease, condition, or problem not listed YES / NO

If so, please list or discuss in confidence with the practitioner...

....

- Are you taking any medications, including vitamins YES / NO

If so, list name and dosage ....

....

- Have you ever taken any drugs affecting calcium and bone metabolism ie Fosamax, Actonel, Aredia, Bonefos, Didrocal, Pamidronate, Pamisol YES / NO

SOCIAL MEDIA –Do you give permission for Port Lincoln Dental Clinic to use images and/or videos of you on social media (Instagram, Facebook or Advertising) where it may be viewed, liked, or shared? YES / NO

I confirm that the above information is correct to the best of my knowledge. I understand that payment for dental treatment is to be made at each appointment, unless other arrangements are made with the dentist prior to treatment. I agree to be liable for any additional costs incurred by collection agencies in recovering fees where necessary.

Signature..**Date**...