Oakleigh Dentist

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PATIENT FORM

Title:_____First Name:_____Surname:_____ Date of Birth:_____

Address:_____

Surburb_____Postcode:_____Home Phone:_____

Mobile:_____ Email:_____

How did you hear about us: _____

Emergency contact Name _____ Emergency contact number_____

MEDICAL HISTORY

Have you had any of the following? Please Indicate:

	Yes	No		Yes	No
High Blood Pressure			Heart Problems (malformations, heart murmurs, hole in the heart, valve disease etc.)		
Rheumatic Fever			Asthma, Chest or Breathing Problems		
Tuberculosis			Stomach or Bowel Problems (Ulcers, Ulcerative Colitis, Crohn's Disease etc.)		
Kidney Disease			Diabetes		
Thyroid Disease (eg. under or over active)			Excessive Bleeding or Blood disorder		
Epilepsy			Hepatitis or other liver disease		
HIV/AIDS			Bone Disorders or Diseases, including bisphosphonate therapy (e.g.Fosamax, Zometa)		
Taking Blood thinners (eg aspiring, Xaralto, Clavix, Warfarin, Pradaxa)			Female patients, are you pregnant?		

Do you have:

	Yes	No
Artificial hip or other joint		
Replacement heart valve		

Are you taking any drugs, medicines, tablets, creams, pastes or sprays? (please list):

_____
_____
_____

Do you have any **allergies** or have you had an adverse reaction to medication (e.g. penicillin, latex, general anaesthetic):

_____

Do you smoke?_____ If yes, how many?_____ Would you like to stop?:_____

Please list any other previous illnesses:_____

Do you have Private Health Insurance?:_____Which Fund?:_____

Thank you for your assistance in completing this form as fully as possible.

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give permission for the practice to use the above contact details to send me appointment and check-up reminders.

Signed:_____ Dated:_____