JAMESTOWN DENTAL

***Personal Details***

First Name _____ Surname_____

Preferred Name _____ Date of Birth _____./_____/_____

Parent/Guardian Name (if under 18)_____

Postal Address _____

_____Postcode _____

Email _____

Phone (H) _____ Phone (M) _____

Occupation_____ Health fund _____

Do you identify as Aboriginal or Torres Straight Islander?_____

Do you hold a current pension or health care card?_____

Who recommended you to our practice_____

***Medical and Dental History***

Do you have any concerns with your teeth or mouth?

_____

Do you require antibiotic cover before dental procedures? Y / N

Do you take any blood thinners or have a bleeding disorder? Y / N

Have you had an adverse reaction to local anaesthetic? Y / N

Have you been hospitalised in the last 12 months? Y / N

Are you a smoker? Y / N

Do you have or have you had any of the following medical conditions? Y/N

- Blood borne disease eg. HIV
- Prosthetic joint eg. Hip, knee
- Prosthetic heart valve
- Diabetes
- Stroke
- Epilepsy
- Cancer
- High or low blood pressure
- Tuberculosis
- Lung disease eg. emphysema
- Heart disease
- Asthma
- Kidney disease
- Cardiac Pacemaker
- Rheumatic Fever
- Stomach/digestive condition
- Thyroid disease
- Liver disease
- Are you currently pregnant
- Bone disease eg. osteoporosis

Do you have any allergies? (eg. penicillin, latex) Please advise details:

_____

Are you taking any medications at present (including vitamins)? Please list:

_____

Who is your GP?_____

Patient/Parent Signature:

_____ Date: _____