Pakington Dental Care Patient information sheet

243 Pakington Street Newtown 3220 Ph: (03) 5229 2222

Surname:……..... Title:……..……

Firstname:…….. DoB:……..

Address:……..…….

Phone: Home:…….…… Mobile:…….…….

Email address:……..

Emergency contact:……. Relationship:……. Phone:……..…

Medical doctor:…….. Address:…… Phone:……..…

Name of person responsible for fees:……...

How did you find us?.....

Do you have dental insurance?..... Which fund?.....

When was your last dental visit……...……

Have you ever suffered from any of the following?

High blood pressure	Yes	No	
Heart ailment	Yes	No	
Rheumatic fever	Yes	No	
Asthma or breathing problems	Yes	No	
Tuberculosis	Yes	No	
Stomach or bowel problems	Yes	No	
Kidney disease	Yes	No	
Diabetes	Yes	No	
Thyroid problems	Yes	No	
Problems with bleeding	Yes	No	
Hepatitis	Yes	No	
Epilepsy	Yes	No	
Osteoporosis (taking Fosamax)	Yes	No	
Are you Pregnant	Yes	No	If so how many weeks?.....

Do you have an artificial heart valve, pacemaker or other prosthesis?.....

Do you smoke?..... How many?.....

Please list any medication you are taking:…….

Do you have any allergies?.....

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE
I have completed this form to the best of my knowledge and understand that failure to make full disclosure may place me at undue medical risk. I also understand that notes, x-rays or models relating to my treatment may be sent to other dental practitioners to aid in my treatment and consent to this.

Signed:……..…… Date:……...……..

PLEASE INFORM OF ANY CHANGES AT FUTURE VISITS