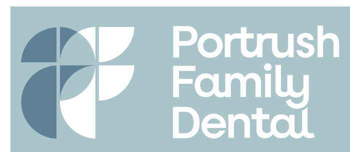

PERSONAL DETAILS

Title: Mr/Mrs/Ms/Miss/Dr Surname: ______________________

Preferred name / Pronouns: ______________________ D.O.B: __________

Private Address: ______________________

Postal Address: ______________________

Occupation: ______________________

Contact Numbers: Mobile __________ Work __________ Home __________

Email Address: ______________________

Emergency contact: Name ______________________ Number __________

How did you hear about us Online / Friend / Family / Website Other:

Are you covered by private health insurance? NO / YES

If yes, which fund? ______________________

Card Reference number? 00 / 01 / 02 / 03 / 04 / 05 / 06

What is the reason for your dental visit today? ______________________

When was your last dental visit ______________________

MEDICAL INFORMATION

Who is your medical practitioner / GP: Name ______________________

Are you taking **ANY** medication or supplements? NO / YES if yes please note below

____

____

Do you have any **ALLERGIES?** NO / YES If yes please list

____

Are you a smoker? (Please circle) No Ex-Smoker YES Social Moderate Heavy

Are you currently pregnant? NO / YES If yes, how many months ______________________

Do you have ANY medical conditions?

- ☐ Asthma or Lung Conditions
- ☐ Previous history or currently undergoing Cancer treatments
- ☐ Heart conditions including Pace makers / Myocarditis / artificial valve
- ☐ Diabetes
- ☐ Previous history of stroke
- ☐ Liver conditions or hepatitis A / B / C
- ☐ HIV
- ☐ Anxiety and / or depression
- ☐ Musculoskeletal conditions including Osteoporosis / Osteoarthritis / rheumatoid arthritis
- ☐ Low / High Blood pressure
- ☐ Rheumatic fever
- ☐ Kidney disease or undergoing dialysis treatment
- ☐ Epilepsy or neurological disorders
- ☐ Acid reflux or GORD
- ☐ Do you have any prosthetic joints? NO / YES

  What year was it placed?
- ☐ Hypo / Hyper thyroid
- ☐ Blood disorders including blood thinning medications

Other ______________________

I certify that the above personal information is true and correct and that I have read and understand the terms and conditions of trade (overleaf or attached) of Portrush Family Dental Pty Ltd which form part of, and are intended to be read in conjunction with this patient form and agree to be bound by those conditions. I authorise the use of my personal information as detailed in the Privacy Act clause therein.

PATIENT TO SIGN SIGNED: Date: