Patient Information and Medical History

Title.....

Surname..... **First names**.....

Date of birth.....**Gender:** M / F

Address.....

..... **Post code**.....

Telephone *(home)* ..... *(mobile).* ..... (*work).*.....

Email ……

Next of kin *(name and phone)*……..

Are you happy to receive SMS messages and/or emails regarding future appointments? Y/N

Occupation.....

Account to *(if other than self)*.....

Do you belong to a private health fund? NO/YES – which one?.....

How were you referred to this practice?

Personal referral ☐*(name)*..... Internet search ☐

School visit/advertising ☐ Walking/Driving past ☐

Other – please specify..... Flyer ☐

A response to each of the following questions will enable us to provide you with the best oral health care.
Do you have or have you previously had: (please circle)

Heart disease	Y / N	Excessive bleeding following surgery or extractions	Y / N
Rheumatic Fever	Y / N	Teeth or jaws broken in accidents	Y / N
Heart Murmur	Y / N	Radiotherapy for cancer to head or neck	Y / N
Diabetes	Y / N	Do you have an infectious disease	Y / N
Abnormal blood pressure	Y / N	Have you had an illness requiring a blood transfusion	Y / N
Nervous disorders	Y / N	Do you smoke cigarettes	Y / N
Asthma	Y / N	Do you have any allergies	Y / N
Epilepsy	Y / N	Please specify……	
Thyroid disease	Y / N	Are you presently being treated by a doctor	Y / N
Hepatitis	Y / N	Stroke / CVA	Y / N
Is there any subject you would like to discuss with the dentist in private	Y / N	Are you pregnant	Y / N

List all medications you are currently taking .....

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Regular medical practitioner name & address.....

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Patient signature.....**Date** .....