

PERSONAL DETAILS (Confidential)

Surname: _____ First Name: _____ Title: _____
 Address: _____ Suburb: _____ Postcode: _____
 Home Phone: _____ Mobile Phone: _____
 Business Phone: _____ Email: _____
 Date of Birth: ____ / ____ / ____ Occupation: _____
How did you find out about us: Yellow pages Internet Word of mouth
 Saw sign/ Building Referral from specialist/Dentist _____ Other _____

Preferred method of contact: Phone Reminder card
Are you happy with the appearance of your teeth? Yes No

MEDICAL HISTORY

Doctor's Name: _____

- Are you currently being treated for any health related issues? Yes No
- Have you been admitted to hospital in the last **two** years? Yes No
- Do you have or have you had any **heart problems**? Yes No
 - Angina Heart Murmur
 - Pacemaker Arrhythmias
 - Valve Replacement/Failure Other: _____

- Have you, or any member of your family, ever had **excessive bleeding** or bruising: Yes No
- **Do you smoke?** Yes No If yes, how many a day? _____

- **Please tick** if you have or have previously had any of the following:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hip / Joint Replacement	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Stomach or Bowel Problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Depressive Illness	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Cancer

- Are you taking any **tablets, medicines, inhalers or injections** of any kind? Yes No
If yes, please list: _____

- Have you previously had an **allergic reaction** e.g. to pills, medicines (e.g. penicillin), latex or local anaesthetic? Yes No
If yes, please list: _____

- **Females:** Are you pregnant? Yes No Due Date _____
 Are you breastfeeding? Yes No

- Appointments not attended or cancelled without 24 hours notice will be charged for.
- Payment is required on the day of treatment. If an account is taken away, an administration of 10% will be added.
- Any unpaid debt will be forwarded to a collection company, expenses incurred in this process will be charged to the patient.
- St Albans Dental Centre reserves the right to discontinue treatment on a patient at our discretion, for any reason.
- St Albans Dental Centre reserves the right to take a sample of blood for analysis in the case of a needle stick injury to a staff member.

I have read the above questionnaire and completed it to the best of my knowledge

SIGNED: _____ DATE: _____

Relationship to patient (if applicable) _____