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:

□ Asthma	**□ Hepatitis**	**□ High Blood Pressure**	**□ Lung Disease**
□ Liver Problems	**□ Stroke**	**□ Hip / Joint Replacement**	**□ Arthritis**
□ Epilepsy	**□ HIV / AIDS**	**□ Stomach or Bowel Problems**	**□ Diabetes**
□ Depressive Illness	**□ Kidney Problems**	**□ Rheumatic Fever**	**□ 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) _____