Drummoyne Dental Surgery

176 Victoria Road, Drummoyne NSW 2047
P.O. Box 505, Drummoyne NSW 1470

PERSONAL DETAILS

Name: ____

Surname **First Names** **Dr / Mr / Mrs / Miss / Ms** **Preferred Name:**

Address: ____

Home Phone: ____________________ **Mobile**: _______________________ **Work Phone:** _____________________

Occupation: ________________________________ **Date Of Birth:** _____________________

E-mail: ____

How would you like to be contacted to notify you are due for a check up and clean?
Please tick appropriate: ❑ **Home ph** ❑ **Work ph** ❑ **Mobile** ❑ **Letter**

Referred By:
- ❑ Yellow Pages
- ❑ Another patient/friend (Name) ___________________________________
- ❑ Street Sign
- ❑ Other (Please specify) ____

Do you have Health Insurance for dental treatment? **Yes/No** **Name of Fund:** _____________________

Details of person to contact in an emergency:

Name: ____ Phone Number: ____________________________________

Medical Doctors Name: _____________________________ Phone (If known): ___________________________________

MEDICAL HISTORY (if Yes, please give details)

1. Are you receiving any medical treatment at the present time? Yes / No
   Details: ____
2. Have you been a patient in hospital during the past two years? Yes / No
   Reason: ____
3. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No
   Details: ____
4. Have you experienced any allergies or unusual effects from: tablets, drugs, injections or anaesthetic? Yes / No
   Details:____
5. Are you, or have you been, under the care of a doctor during the past two years? Yes / No
   Reason: ____
6. Do you smoke? Yes/No If yes, how many cigarettes a day? ___________________________
7. Have you ever had or have any of the following? If so, please tick as appropriate.

- ❑ Heart Trouble
- ❑ Bronchitis/Chest Problems
- ❑ Depressive Illness
- ❑ Severe Headaches
- ❑ Anaemia
- ❑ Rheumatic Fever
- ❑ High Blood Pressure
- ❑ Hepatitis – Type A, B or C
- ❑ Osteoporosis
- ❑ Kidney Trouble
- ❑ Cold Sores
- ❑ Diabetes
- ❑ Asthma
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Gastric Problems
- ❑ Drug Dependence

8. Have you had any prosthetic surgery? If yes, when? (E.g. Heart Valve, Hip Replacement, Knee Replacement etc) Yes / No
   Details: ____
9. Women Only: Are you pregnant? Yes / No If so, how many months: ___________________

DENTAL HISTORY

1. Name of Last Dentist: ______________________________(if you wish your records to be transferred over please let us know)
2. Approximate date of last dental visit:
   Details: ____
3. Do you have Dental pain or a Dental problem at present? Yes / No
   Details: ____
4. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

I acknowledge that I am responsible for all costs of treatment incurred. Payment for treatment is due on the day of treatment.

Signed: Patient/Parent/Guardian _____________________________________ Date: ___________________________