

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_  
 Postal Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Name of friend/relative: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Medical Doctor: \_\_\_\_\_ Previous Dentist: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Private Health Insurance: \_\_\_\_\_ Member Number: \_\_\_\_\_ Reference Number: (Number next to your name) \_\_\_\_\_  
 Medicare Number: \_\_\_\_\_ Medicare Reference Number: \_\_\_\_\_

**GENERAL HEALTH RECORD:** Tick in the square if conditions apply to you:

<input type="checkbox"/> Blood Pressure High__ Low__	<input type="checkbox"/> Diabetic Type: ____	<input type="checkbox"/> Nerves or Anxiety
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Thyroid Condition Type: _____	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cirrhosis of the Liver	<input type="checkbox"/> Stroke	<input type="checkbox"/> Prolonged bleeding/Anticoagulant treatment
<input type="checkbox"/> Hepatitis or Jaundice	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> Pregnant _____ months	<input type="checkbox"/> fainting or dizziness
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Difficulty in swallowing
<input type="checkbox"/> Tumours or Cancers	<input type="checkbox"/> Pleurisy, pneumonia	<input type="checkbox"/> Sinusitis

**ANY MEDICATIONS/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:**

<input type="checkbox"/> Sulphur Drugs	<input type="checkbox"/> General Anaesthetics	<input type="checkbox"/> Latex
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anaesthetics	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Antibiotics Type: _____
<input type="checkbox"/> Sleeping Pills	<input type="checkbox"/> Metal	<input type="checkbox"/> Food/Other: _____

**DENTAL HISTORY:**

<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Food catching in between teeth	<input type="checkbox"/> Abscess, cysts or gum boils	<input type="checkbox"/> Reoccurring mouth ulcers
<input type="checkbox"/> Halitosis: Bad breath	<input type="checkbox"/> Grind or clench teeth	<input type="checkbox"/> Difficult extractions	<input type="checkbox"/> Clicking jaw
<input type="checkbox"/> Difficulty chewing	<input type="checkbox"/> infected gums, loose teeth	<input type="checkbox"/> Dry sockets after extractions	<input type="checkbox"/> Orthodontic treatment

Regular medications: \_\_\_\_\_  
 \_\_\_\_\_

Major Medical Operations: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_