aardent
DENTAL CENTRE

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:

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

ANY MEDICATIONS/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:

- ☐ Sulphur Drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Sleeping Pills
- ☐ General Anaesthetics
- ☐ Local Anaesthetics
- ☐ Sedatives
- ☐ Metal
- ☐ Latex
- ☐ Penicillin
- ☐ Antibiotics Type: _____
- ☐ Food/Other: _____

DENTAL HISTORY:

- ☐ Bleeding gums
- ☐ Halitosis: Bad breath
- ☐ Difficulty chewing
- ☐ Food catching in between teeth
- ☐ Grind or clench teeth
- ☐ infected gums, loose teeth
- ☐ Abscess, cysts or gum boils
- ☐ Difficult extractions
- ☐ Dry sockets after extractions
- ☐ Reoccurring mouth ulcers
- ☐ Clicking jaw
- ☐ Orthodontic treatment

Regular medications: _____

_____

Major Medical Operations: _____

Signature: _____ Date: _____