m e n d

D E N T A L

Dr Ms Mr Mrs Miss (Full name) ……………………………………………………….Date of Birth………………………

Address ………..

Occupation ………………………………………Home phone………………………Work phone…………………………..

Mobile………………………………………….. Email………………………………………………………………………….

Name of Health Fund………………………………………Membership #.................................Ref #................

Medicare # ………………………………………….. Ref # ……………………….

<u>Emergency Contact</u>

Name……………………………………………. Phone #.................................... Relation…………………………………

GP's Name……………………………………… Phone #.................................... Suburb…………………………………

<u>Medical History</u> *(please tick)*

- Heart Problems
- Artificial Joints
- Hip Replacement
- Knee Replacement
- Rheumatic Fever
- Excessive Bleeding
- HIV/AIDS
- Allergies to Penicillin
- Allergies to Anaesthetics
- Allergies to Latex
- Tumour History
- Tuberculosis
- Epilepsy
- Anxiety/Depression
- High/Low Blood Pressure
- Diabetes
- Asthma
- Hepatitis A, B, C, D, E
- Liver/Kidney problems
- Blood Disorders
- Osteoporosis

Are you currently taking any Medications? Yes / No

If 'YES', please list…………………………………………………………………………………………………...................................

Are you undergoing treatment for Osteoporosis? Yes / No

Are you considering or currently taking Bisphosphonates I.e. Fosamax or Prolia Yes / No

Do you take Blood thinners? Yes / No

Do you take Fish Oil? Yes / No

Are you a smoker? Yes / No

If female, are you pregnant? Yes / No

<u>Dental History</u> *(please circle)*

Have you ever had a filling? Yes / No **Have you ever had a crown?** Yes / No

Have you ever had gum disease? Yes / No **Have you ever had a dental Implant?** Yes / No

Do you feel you grind your teeth? Yes / No **Have you ever had Root Canal treatment?** Yes / No

Do you wear a night guard? Yes / No **Do you have sensitivity?** Yes / No

When was your last dental appointment? ……………………………………………………………………………..

Who may we thank for referring you?...

***** Accounts are to be settled at the completion of each appointment *****

Mend Dental values our patients time, we strive to strictly honour the appointment times we make with you. However, because of complications we may run late. Should you not be able to keep the appointment reserved for you we expect 24hours notify of cancellation otherwise a non-attendance fee may result.

Signed…………………………………………………………………………………Date……………………………………