Welcome to **Bellevue Hill Dental.**

bhd Bellevue Hill DENTAL

Phone: **(02) 9389 4748**

In order to provide treatment of high standard, it is necessary to have the following information, which will be handled confidentially.

Patient Details

Surname: ______ Given Name: ______

Title: ◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr

Occupation: ______

Date of Birth: ______ Residential Address: ______

Suburb: ______ Post Code: ______

Contact: (Home) ______ Mobile: ______

Email: ______

What number listing are you on your Health Fund card?

Private Health Fund: ______

◯ 00 ◯ 01 ◯ 02 ◯ 03 ◯ 04 ◯ 05 ◯ 06

Who referred you / How did you hear about our practice ?

◯ **Google** ◯ **Internet** ◯ **Walked By** ◯ **Oventus** ◯ **Another Patient/Friend Who?** ______

Emergency Contact Name: ______ **PH:** ______ Relation: ______

Name of Your Doctor: ______ **PH:** ______ Suburb: ______

Medical History

Condition			Condition		
Abnormal Bleeding	◯ Yes	◯ No	Heart Attack	◯ Yes	◯ No
Angina	◯ Yes	◯ No	**Heart Murmur**	◯ Yes	◯ No
Artificial Heart Valves/Valve Defect	◯ Yes	◯ No	Hepatitis ☐ A ☐ B ☐ C ☐ D	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	HIV AIDS Positive	◯ Yes	◯ No
Blood Pressure ☐ **High** ☐ **Low**	◯ Yes	◯ No	Nervous Disorders	◯ Yes	◯ No
Bone Disease	◯ Yes	◯ No	Oral Cancer	◯ Yes	◯ No
Cardiac Surgery/Pacemaker	◯ Yes	◯ No	Pregnant? Due Date ______	◯ Yes	◯ No
Congenital Heart Defect	◯ Yes	◯ No	Rheumatic Heart Disease	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Suffer from grinding/clenching teeth	◯ Yes	◯ No	**Sleep disorders/snoring**	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No	Warfarin Medication	◯ Yes	◯ No
Joint Replacement	◯ Yes	◯ No	Thyroid Disorder	◯ Yes	◯ No
Infectious Diseases	◯ Yes	◯ No	Other Serious Illness ______		

Are You Taking Medication? ◯ Yes ◯ No (Please List Below)

______ ______ ______

Dental Allergies

Penicillin ◯ Yes ◯ No Aspirin ◯ Yes ◯ No Iodine ◯ Yes ◯ No Sulpher ◯ Yes ◯ No Latex ◯ Yes ◯ No

Other: ______

Dental History

Reason for presenting to the surgery? ◯ **Consultation** ◯ **Pain** **Other** ______

Are you interested in whitening the colour of your teeth? ◯ Yes ◯ No

Are you interested in cosmetically enhancing your smile? ◯ Yes ◯ No

As a patient of Bellevue Hill Dental you are required to provide 48 hours notice to cancel or change your appointment. If you provide less that 48 hours notice you may be required to pay a holding deposit for further treatment

By signing below you agree to the above terms and conditions of Bellevue Hill Dental.

Patients Signature: ______ **Date:** ______