

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

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

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 than 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: