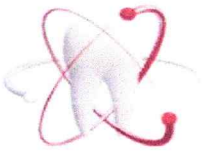

Woodford Dental

www.woodforddental.com.au

Welcome

Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best treatment for you.

All information will be treated with complete professional confidentiality.

Personal Details

Title Prof / Dr / Mr / Mrs / Miss / Ms / Other

Surname_____First name_____Date of birth_____

Home address_____

Suburb_____Postcode_____Email address_____

Home Phone_____Mobile_____Business Phone_____

Name of emergency contact person_____Their Phone Number_____

Do you have dental insurance? Yes / No If yes which fund_____

Medical History

I have confidential medical information that I do not wish to write down. I would prefer to speak to the dentist about this. (please tick)_____

Doctors Name_____Phone number_____

Please list current medications_____

Please list any known allergies (including drugs,Medicine and latex)

_____

Are you currently taking osteoporosis medication Yes/No Are you a smoker Yes/No

Women, Are you pregnant? Yes/No If yes how many weeks_____

Have you had any of the following?

Asthma	Yes/No	Rheumatic Fever	Yes/No	Tuberculosis	Yes/No
Epilepsy	Yes/No	Excessive Bleeding	Yes/No	High Blood Pressure	Yes/No
Diabetes	Yes/No	Kidney Disease	Yes/No	Heart Ailment	Yes/No
Aids/HIV	Yes/No	Hepatitis A,B,C	Yes/No	Prosthetic implant	Yes/No

Any other medical condition(s) not mentioned (please list)-

_____

Have you been Hospitalised in the last 5 years? Yes/No If yes, what for?_____

Dental History

Do you normally require antibiotic cover before dental treatment? Yes/No

Have you ever had any problems with dental treatment? Yes/No

Have you had your wisdom teeth removed? Yes/No

Does dental treatment make you nervous? Yes/No

Are you aware of chenching or grinding your teeth, day or night? Yes/No

Date of last dental visit_____

What is the purpose of today's visit?_____

How did you know about us?

Recommended by someone_____Other_____

I Have completed the above to the best of my knowledge and understand that failure to make a full disclosure may place me under medical risk. Ialso understand that i am fully responsible for the financial aspect of my dental treatment.

Signed_____ Date_____