## **Patient Details Form**



In order for us to perform dental treatment of a high standard, it is necessary for you to answer the following questionnaire. All information will be handled confidentially. Please fill in this form completely on both sides,

Personal	l Detail	S
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Title Mr Mrs Ms Miss Dr

Given Names Surname

Preferred Name Date of Birth

Address

Suburb State Post Code

Home Phone Mobile

Occupation Employer/School

Email

Health Fund None Hospital Dental Both Health Fund

Medicare No Number you are on card

Emergency contact name, number & relationship

Preferred appointment reminder SMS (Text Message) Phone Mobile Phone Home Email

Patients under 18 years of age: Names of ALL parents/legal guardians

**Consent for Treatment** I, the undersigned, hereby give my consent to treatment which I, in consultation with the staff of Happy Smiles Dental Care, agree to be necessary or advisable, including the administration of anaesthetic as necessary. I assume responsibility for fees associated with this treatment. I understand and comply with the 24hr Cancellation policy as well as any fees that may occur as a result of missed appointments.

Signature Date

#### **Dental History**

Previous Dentist/Practice Last Appointment

Have you experienced abnormal reactions during or following dental treatment? Yes No

Have you been told you require antibiotics prior to dental treatment for medical reasons? Yes No

### **Medical History**

Medical GP/Practice Name

Do you smoke? No Previously Currently Per day

Women, Are you currently pregnant or breastfeeding? Yes No

If pregnant please specify due date

Do you identify as Aboriginal or Torres Strait Islander Yes No

Do you have any allergies (please include all allergies)?

Yes No

Penicillin Latex Other allergies

Anaphylaxis? Yes No Do you carry an Epi pen? Yes No

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### Medical History (Cont.)

Any heart complaint or treatment, Inc	cluding si	urgeries an	d condition	S				Yes	No
Epilepsy	Yes	No	HIV / other blood borne viruses					Yes	No
Rheumatic Fever	Yes	No	Stroke					Yes	No
Infective endocarditis	Yes	No	Nervous system disorder					Yes	No
High blood pressure	Yes	No	Asthma					Yes	No
Low blood pressure	Yes	No	Bronchitis / Lung conditions					Yes	No
Bleeding disorder	Yes	No	Hepatitis A B					С	No
Liver disorder	Yes	No	Hyperthyroidism					Yes	No
Kidney disease	Yes	No	Hypothyroidism					Yes	No
Sleep Apnoea	Yes	No	Do you have a CPAP?					Yes	No
Arthritis	Yes	No	Osteoporosis/Bone Disease					Yes	No
Depression	Yes	No	Gastric Reflux/GORD/GERD					Yes	No
Anxiety	Yes	No	Ulcer/Digestive conditions				Yes	No	
Cancer	Yes	No	Treatment of Cancer					Yes	No
If yes, please specify cancer type, location treated and when treatment took place									
Joint Replacement Surgery	Yes	No	Which joint and year placed						
ASD / ADHD / Aspergers / Sensory								Yes	No
If yes, please specify									
Diabetes Type 1/Type 2/Gestational/F	Pre		Type 1	Type 2	Gesta	ationa	I	Pre	No
Have you ever taken a bisphosphonate, similar acting drugs or do you have regular injections with you GP (e.g Fosmax, Actenol, Prolia) these are often used to treat osteoporosis or bone cancer  Y								your Yes	No
If yes, please list which type, frequence	cy and las	st dose give	en						
Please list all current medications (Prescriptions, over the counter or herbal)									

## **Submit Details**

Yes

No

Any other medical conditions or details of medical conditions specified? (please list)