melville dental care registration and medical information

The thoroughness of this medical history is designed for your safety.
Your complete answers will assist us in treating you with consideration for your individual needs.

Registration

Last name:_____ Title: Mr Mrs Ms Miss Mst Dr

First Names:_____ I prefer to be called:_____

Date of Birth:_____ Occupation:_____

Home address:_____Post Code:_____

Mailing address:_____ Post Code:_____

Home phone:_____ Mobile:_____

Business phone:_____ Email:_____

Fax number:_____ *We request you list at least two phone numbers, thank you.*

Private health fund (dental) No Yes – Fund name _____

Who can we thank for referring you? _____

Emergency Contact Person: _____ Relationship_____

Contact details_____

Medical History

GP /Physician Name:_____ Location/telephone:_____

Are you currently under the care of a physician? No Yes- Reason:_____

Have you been hospitalised in the last 5 years? No Yes – Reason:_____

Do you have, or have you ever had any of the following: **Please tick box for Yes**

	Yes ✓		Yes ✓		Yes ✓
Tuberculosis		Emphysema		Hepatitis A B C	
Kidney disease		Liver disease		Arthritis	
Psychiatric care		Immune deficiencies		Respiratory problems	
Asthma		Swollen ankles		Malignancies	
Herpes		Fainting		Diabetes	
Nervous problem		Seizures		Stomach problems	
Radiation treatment		Hay fever		Thyroid problems	
Allergy to drugs		*Joint replacement		Allergy to anaesthesia	
Neck/back problems		Glaucoma		Joint problems	

Please detail:_____

Please turn over…

Do you have, or have you ever had any of the following blood diseases? **Please tick box for Yes**

	Yes ✓		Yes ✓		Yes ✓
Anaemia		Leukaemia		Sexually transmitted	
Positive HIV test		Excessive bleeding		Other	

Please detail:_____

Do you have, or have you ever had any of the following cardio-vascular diseases: **Please tick box for Yes**

	Yes ✓		Yes ✓		Yes ✓
Angina		Heart attack		Heart surgery	
Rheumatic fever		*Heart murmur		High blood pressure	
Stroke		*Congenital heart defect		Low blood pressure	
Arteriosclerosis		*Mitral valve prolapse		Circulatory problems	
Cardiac pacemaker		Bypass		Other:	

Please detail:_____

Allergies (e.g. Penicillin, latex)

Anaesthesia:_____

Drugs:_____

Environment: _____

Are you taking <u>any</u> medications or supplements at this time: No Yes- Please detail:

Name Quantity Reason Duration

_____

_____

Have you taken: (Please circle) Aspirin (daily) **Warfarin Plavix Fosamax Bisphosphonates Osteoporosis Medication**

How would you rate your health at this time: _____

Female patients, are you pregnant? No Yes – Due date:_____

Do you drink alcohol? No Yes – Drinks per day:_____

Do you smoke tobacco? No Yes – Quantity per day:_____ (Ex) Smoker for _____ years

*Have you ever been advised to take prophylactic antibiotics for dental treatment due to medical condition? No Yes

Name and prescription of the antibiotic: _____

Please list any other conditions this practice should be made aware of:

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I will advise the practice to any future changes to the above information. I understand I will be asked to update this information regularly. I also understand notes, x-rays or models relating to my treatment may need to be sent to other practitioners to aid them in my treatment, and give my permission for this to occur when necessary.

Signed:_____ Date:_____

Thank you and welcome to our practice!