CRESCENT VILLAGE
DENTAL CENTRE

Welcome to our practice

Title (Mr/Mrs/Miss/Ms) **First Name**..... **…Family Name**.....

Address..... **Suburb & Postcode**.....

Home Phone …..... **Mobile**.....**Work Phone**.....

Date of Birth...../...../..... **Occupation**……**Email**……

How did you hear about our practice?……

Do any family members at the same address attend this practice?……

Which Health Fund Do You Belong To? .... HBF/Medibank/BUPA/VETERANS AFFAIRS/ OTHER -……

Reason you are attending today.....

MEDICAL QUESTIONAIRE – PRIVATE AND CONFIDENTIAL

The state of your health may have significant effect on your dental care.

Name And Address Of Your Medical Practitioner......

Please List Any Medicine You Are Taking, Prescribed And/Or Over The Counter:

.....

.....

Please indicate if you have or ever had any of the following:

Rheumatic Fever	Y/N	**Any Heart Complaint/Treatment**	Y/N
High Blood Pressure	Y/N	**Low Blood Pressure**	Y/N
AIDS/HIV	Y/N	**Diabetes**	Y/N
Hepatitis(A)(B)(C)	Y/N	**Joint Replacement Surgery**	Y/N
Epilepsy	Y/N	**Thyroid Disease**	Y/N
Tuberculosis	Y/N	**Asthma**	Y/N
Osteoporosis	Y/N	**Allergy To Latex**	Y/N
Blood Thinning Treatment	Y/N	**Radiation Therapy/ Chemotherapy**	Y/N

Allergies To Any Medicine Or Chemicals? (Please Specify).....

.....

Do You Smoke? Y/N **If Yes, How Many Per Day?** .....

Ladies, Are You Pregnant? Y/N **If Yes, When Are You Due?** .....

Are You Breast Feeding? Y/N

In signing this form I acknowledge that this represents an accurate medical history. I will advise my dentist of any changes in the future and I understand that all my details will be treated with complete professional confidentiality.

Signed..... **Date**...../...../.....

Parent / Guardian (If under 18 years of age.)Name……Signed……