Personal Medical and Dental Information Sheet

Woonona Dentists
Over 40 Years Trusted Service

Personal Details

Title:	First Name:	Surname:	Date of birth:
Address:			
Suburb:		Post Code:	Home phone:
Mobile:		Email:	
Occupation:		Work Phone:	
Emergency Contact (Name & relationship):			Contact No:

Private Health Insurance

Private Health Fund (Name):	Member Number:	Your No. on Card:
Medicare Card No:	Reference Number	Expiry Date:

How You Heard About Us

☐ Flyer in the mail ☐ Window Signage ☐ White Coat ☐ News paper ad ☐ Friends/Family

☐ Website ☐ Facebook ☐ Google Search ☐ Local School ☐ Journey Magazine ☐ Other_____

How would you like to be reminded about your 6 monthly routine check-up? ☐ Letter ☐ SMS ☐ Email

Medical History

Your Doctor's(GP) Name:_____ Suburb:_____ Telephone: _____

Have you ever had or do you have any of the following condition/s (Please tick)

☐ High Blood Pressure
☐ Stroke
☐ High Cholesterol
☐ Arthritis
☐ Respiratory/ Lung Disease
☐ Cardiac/Heart Disease
☐ Broken Bones_____
☐ Ulcer
☐ Bowel Issues
☐ Anxiety
☐ Digestive Problems
☐ Mental/Psychological Issues: _____
☐ Diabetes: __ 1_ or__ 2____
☐ Hepatitis A/B/C
☐ Cancer: _____
☐ Asthma
☐ Bleeding Disorder
☐ Urinary/Kidney Issues
☐ Neurological (nerve) problems
☐ Osteoperosis
☐ HIV
☐ Immunity Problems

Are you undergoing Radiotherapy or Chemotherapy? ____☐ Yes ☐ No
Are you on any anti-coagulant therapy? _____ ☐ Yes ☐ No
Are you on oral/IV bisphosphonates? _____ ☐ Yes ☐ No
Are you Pregnant or possibly pregnant? _____ ☐ Yes ☐ No
Are you on Warfarin?_____ ☐ Yes ☐ No
Are you on Prolia Injections? ?_____ ☐ Yes ☐ No When was your last injection? _____
Do you Smoke? _____☐ Yes ☐ No

List of Any/All Current Medications/Conditions:

If your medical conditions change, please inform the reception staff at your next visit. Information about your medical history is for Dentist's use only.

Previous Surgery (Please Specify): _____Other illness or condition: _____

Any Allergies? ☐ NO ☐ YES ☐ Penicillin ☐ Latex ☐ Other _____

Previous dental examination? _____ Purpose of your appointment today: _____

The information provided is true to best of my knowledge. I understand that failure to make full disclosure of my medical condition may place me in undue medical risk and may compromise my dental treatment.

Patient/Guardian Signature_____ **Date:** _____

Last Updated: 11.6.19