Advanced DentalServices

Complete Family Care

Patient's Name (please print) Mr/Mrs/Ms/Miss/Dr

____

Address ______________________________

Suburb ______________________________

State ______________ Postcode ______________

Sex ☐ Male ☐ Female

Date of Birth ______________ Age ______________

Phone (H) ______________ (W) ______________

Mobile ______________ Email ______________

Patient's Occupation ______________________________

Are you in a health fund? ☐ Yes ☐ No

Fund name ______________ card number ______________

Do you hold a Veterans Affairs Gold Card? ☐ Yes ☐ No

Medicare card number ______________________________

We are grateful that our practice grows by referral,
Who should we thank for referring you?

____

Have you ever been treated here before? ☐ Yes ☐ No

1. General Health
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Are you under the care of a doctor for any medical conditions?
   ☐ Yes ☐ No
   If yes, please explain ______________________________
   ____
   ____

3. Name and address of family doctor
   ____
   ____

4. Are you wearing a pacemaker or heart valve prosthesis or do you have a joint replacement or any other medical implant?
   ☐ Yes ☐ No
   If yes, please explain ______________________________
   ____

5. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
   ☐ Yes ☐ No
   If yes, please explain ______________________________
   ____

6. Are you taking any kind of medications (prescribed or non-prescribed) or drugs at this time?
   ☐ Yes ☐ No
   If yes, please explain ______________________________
   ____
   ____
   ____

7. Have you been diagnosed as having **HIV, AIDS** (Acquired Immune Deficiency) or ARC (Aids Related Complex)?
   ☐ Yes ☐ No

8. Are you pregnant?
   ☐ Yes ______________ Months ☐ No ☐ N/A

9. Are you allergic or have had an unusual reaction to any of the following (please circle)

   Penicillin Aspirin Nitrous Oxide Sulpha Drugs
   Codeine Steroids Erythromycin Valium
   Sedatives Ibuprofen **Latex! Rubber** Flagyl
   Other ______________________________

10. Do you have a history of any of the following disorders? (Circle)

Lung Disease	**Blood Disorders**	Anaemia	Stomach Ulcer/Reflux
Sinus Trouble	Thyroid Trouble	Asthma	Fainting Spells
Heart Trouble	**Heart Attack**	Herpes	Chronic Bronchitis/Cough
Hay Fever	Heart Murmur	Arthritis	Shortness of Breath
Kidney Trouble	**Convulsions**	**Diabetes**	**Rheumatic Fever**
Tuberculosis	Epilepsy	Glaucoma	**Cancer Treatment**
Hepatitis A	Depression	Angina	Psychiatric Treatment
Hepatitis B	Migraine	**Stroke**	High Blood Pressure
Hepatitis C	**Sleep Apnoea**	Palpitations	Hives or Skin Rash

11. Do you currently receive, or have you ever received, occasional injections by a doctor or specialist for Osteoporosis? ☐Yes ☐No

12. Have you ever taken any of the following medications (Please circle)

    Fosamax Didrocal Didronel Skelid
    Actonel Pamisol Aredia Bonefos
    Zometa Alendro Boniva **Aclasta**

13. Is there anything else about your health we should know?

I agree the above information is to the best of my knowledge are true and correct

Signature ______________________________ **Date** ______________ .

We provide treatment plan options for major Dental Work; let us know if you want to know more.