**Bega Dental Practice Patient Details Form (CONFIDENTIAL)**

Title: …………..…… First name: ………….…………….…….………...... Surname:….…….………….…..………….……… Date of Birth: …….………...........

Address: ………………………………………………………………………………………………………………………………………………………………………………………….

Mobile: ………………………..…………..…Home Phone:……………..…..…… Work Phone: ………………………… Occupation: ……………………………..

Email: …………………………………………………………………………………………….……………………… Veteran Affairs Gold or Silver? ……………………..

Emergency Contact (name and contact info): ………………………………………………………… Health Fund for Dental?………………………………..

Medical GP and Practice: ………………………………………………………………………………………………………………………………………………………………..

**Please indicate whether you/the patient have or have had any of the following conditions and *provide further information where relevant.***

**\*\*\*\*\*If multiple options are listed PLEASE CIRCLE the most appropriate.\*\*\*\*\***

 **NO YES UNSURE**

|  |  |  |  |
| --- | --- | --- | --- |
| Heart problems (e.g. rheumatic heart disease, congenital heart disease, heart murmur, atrial fibrillation, heart attack, angina, stroke, endocarditis, other) |  |  |  |
| Heart surgery (e.g. pacemaker, bypass, stent, valve repair or replacement, other) |  |  |  |
| High or low blood pressure |  |  |  |
| Difficulty breathing |  |  |  |
| Asthma |  |  |  |
| Sinus problem |  |  |  |
| Snoring |  |  |  |
| Sleep apnoea |  |  |  |
| Brain or nerve related condition (e.g. Epilepsy, Parkinson’s, Alzheimer’s, Dementia, Motor Neurone Disease, Other) |  |  |  |
| Diabetes |  |  |  |
| Liver disease or jaundice |  |  |  |
| Kidney disease |  |  |  |
| Osteoporosis |  |  |  |
| Have you ever taken medication prescribed by your doctor for your bones including tablets, injections or infusions? (e.g. Fosamax, Prolia, Actonel, Aclasta, other) |  |  |  |
| Arthritis |  |  |  |
| Stomach ulcers |  |  |  |
| Reflux |  |  |  |
| Thyroid issues |  |  |  |
| Physical disability |  |  |  |
| Alcohol or drug dependence |  |  |  |
| Cancer |  |  |  |

**\*\*\*\*\*Please complete the questions on the back of this page\*\*\*\*\***

 **NO YES UNSURE**

|  |  |  |  |
| --- | --- | --- | --- |
| Chemotherapy or radiotherapy to your head and/or neck |  |  |  |
| Infectious disease (e.g. HIV, tuberculosis, drug resistant infection, hepatitis, other) |  |  |  |
| Diagnosed with a mental illness |  |  |  |
| Allergies or reactions (e.g. Penicillin or other antibiotics, latex, mint, dairy, other) |  |  |  |
| Blood or bleeding disorder (e.g. excessive bleeding or bleeding for too long after surgery or dental extraction, clotting, deep vein thrombosis, anaemia, haemophilia, other) |  |  |  |
| Difficulty having dental treatment (e.g. getting numb, anxiety, other) |  |  |  |
| Are you or might you be pregnant? |  |  |  |
| Breastfeeding |  |  |  |
| Behavioural conditions (e.g. ADD/ADHD, autism spectrum disorder, other) |  |  |  |
| Developmental delays |  |  |  |
| Do you play sport or participate in an activity that might require a mouthguard? |  |  |  |
| Current or past smokerIf yes, how many cigarettes \_\_\_\_\_\_\_\_\_\_ per day? For how long \_\_\_\_\_\_\_\_\_ years? If you have stopped smoking, when did you stop? |  |  |  |
| AlcoholIf yes, how often? [ ] Daily [ ] Weekly [ ] Monthly |  |  |  |
| Blood thinning medication (e.g. Aspirin, Warfarin, fish oil, other) |  |  |  |
| Steroid therapy or any medication that suppresses the immune system |  |  |  |
| Hospitalised or had an operation in the past 2 years |  |  |  |
| Other, please specify: |  |  |  |

Please list any medications you are currently taking or have taken in the past year, including prescription, over the counter and complementary medicines – tablets, capsules, ointments, inhalers, eye drops, ear drops, injections, implants, infusions, patches.

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What is the purpose of your visit here today? ………………………………………………………………………………………………………………………………

I have completed this questionnaire to the best of my knowledge and understand that failure to make full disclosure may place me at undue medical risk.

Sign: ………………………………………………………………………………………………………………………….. Date: ……………………………………………………...

**Thank you for completing this form.**

**If there is anything we can do to make you/the patient’s visit more comfortable please let us know.**