

**DEAR PATIENT, WELCOME TO OUR OFFICE!**

**Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.**

FULL NAME: Mr Mrs Ms Miss Mast .....

ADDRESS: .....

HOME PHONE: ..... WORK PHONE: ..... MOBILE: .....

Email: ..... Health Fund:.....

DATE OF BIRTH: ..... / ..... / ..... EMPLOYER / OCCUPATION: .....

NEAREST RELATIVE (Not at your address): .....

ADDRESS: ..... PHONE: .....

PERSON RESPONSIBLE FOR FEES: .....

PLEASE TELL US HOW YOU DISCOVERED OUR PRACTICE .....

**MEDICAL HISTORY**

WHO IS YOUR DOCTOR? ..... TELEPHONE .....

DO YOU TAKE DRUGS OR PRESCRIBED MEDICINE REGULARLY? Yes / No

If yes, please list .....

HAVE YOU HAD ANY SERIOUS HEALTH PROBLEMS DURING THE PAST YEAR Yes / No

ARE YOU AWARE OF HAVING AN ALLERGIC (OR ADVERSE) REACTION TO ANY MEDICATION OR SUBSTANCE? Yes / No

If yes, please list .....

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD, OR HAVE AT PRESENT.  
CIRCLE "YES" OR "NO" TO EACH ITEM.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Blood Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S. / HIV Positive	Yes No
Heart Murmur	Yes No	Tumors	Yes No	Kidney & Liver Trouble	Yes No
High Blood Pressure	Yes No	Contact Lenses	Yes No	Cold Sores/fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Artificial Joint (hip, knee, etc)	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Psychiatric / Psychological Care	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis / Rheumatism	Yes No	Hay Fever	Yes No	Chemotherapy	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Nervous / anxious	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Troubles	Yes No	Epilepsy or Seizures	Yes No
Diet (Special / Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No

**Women:** Are you pregnant? Yes ..... Months / No **Nursing?** Yes / No **Taking birth control pills?** Yes / No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. Station Square Dental Centre, it's employees & associates will respect the confidentiality of the above information and will only contact another healthcare provider for further information with the patients permission unless there is an emergency. Station Square Dental Centre is compliant with all requirements of the Privacy Act as required by law. I will notify the dentist of any change in my health or medication.

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_