Please Turn Over

COMFORT CARE DENTAL

(Mr/Mrs/Ms/Miss) First Name: ____________________ Last Name: ____________________________

Address: ____ Suburb: ____________________

State: _______ Postcode: ______ Home No: _________________ Mobile No: ____________________

D.O.B:___/___/______ Email: ____________________________________ Health Insurance: Yes / No

Health Fund:____________ Membership Number: ______________________ Member Number: _____

Occupation: ____________________ Employer: ____________________ Work No: ______________

Next of Kin: __________________ Relationship: _______________ Contact No: __________________

Who will be responsible for this account: ◯Self ◯Other: _____________________________________

How did you hear about us:___________________________ ◯ I have previously attended this practice

Medical History

Please tick Yes or No & circle the relevant

Anaemia	◯Yes ◯No
Angina	◯Yes ◯No
Arthritis	◯Yes ◯No
Artificial Joints	◯Yes ◯No
Asthma	◯Yes ◯No
Back/Neck Problems	◯Yes ◯No
Blood Disease	◯Yes ◯No
Blood Disorder	◯Yes ◯No
Cancer	◯Yes ◯No
Chemotherapy	◯Yes ◯No
Cold Sores	◯Yes ◯No
Diabetes	◯Yes ◯No
Epilepsy/Seizures	◯Yes ◯No
Excessive Bleeding	◯Yes ◯No
Fainting/Dizziness	◯Yes ◯No
Hay Fever	◯Yes ◯No
Heart Attack/Disease	◯Yes ◯No
Heart Arrhythmia	◯Yes ◯No
Heart Pacemaker	◯Yes ◯No
Heart Valve	◯Yes ◯No
High Blood Pressure	◯Yes ◯No

Hepatitis A / B / C	◯Yes ◯No
HIV/AIDS	◯Yes ◯No
Joint Replacement	◯Yes ◯No
Liver Disease/Jaundice	◯Yes ◯No
Low Blood Pressure	◯Yes ◯No
Osteoporosis	◯Yes ◯No
Radiation Treatment	◯Yes ◯No
Reflux	◯Yes ◯No
Sinus Problems	◯Yes ◯No
Smoker	◯Yes ◯No
If so, how many per day: ________	
Stroke	◯Yes ◯No
Thyroid Issue	◯Yes ◯No
Tuberculosis	◯Yes ◯No

Any Other Medical Conditions:

____

____

____

____

____

Name of GP or Drs Surgery

____

Ladies, are you pregnant?

◯Yes ◯ Not Sure ◯No

If so, how far along? ____________

Are you breastfeeding ◯Yes ◯No

Allergies

Any Known Allergies	◯Yes ◯No
Aspirin	◯Yes ◯No
Codeine	◯Yes ◯No
Latex	◯Yes ◯No
Local Anaesthetic	◯Yes ◯No
Penicillin	◯Yes ◯No
Sulpha	◯Yes ◯No

Please list any other allergies:

____

____

____

Are you currently taking any medication ◯Yes ◯No - **Please list below** (e.g. aspirin, warfarin, fosamax etc.):

____

____

Dental History

Reason for today's visit: ____

Last visit to the dentist: ____________________ Last dental x-rays taken: ______________________

Please tick [✓] if you DO NOT wish to have your photos used for education marketing ◯

Please tick [✓] if the following is relevant to you:

Jaw Pain / Clicking / Popping	◯	Braces/Plate| Full/Partial Denture	◯
Bleeding / Inflamed Gums	◯	Occasional Bad Breath	◯
Loose / Broken Teeth	◯	Snoring or Sleep Apnoea	◯
Sensitivity to Hot / Cold	◯	Sensitivity to Sweet Foods	◯
Painful to Bite	◯	Teeth Grinding	◯
Mouth Ulcers / Growths	◯	Wisdom Teeth Removed	◯
Dental Implant/s	◯	Require Antibiotics When Treated	◯

DECLARATION:

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

Patient Signature: ____________________________________ Date: ____________________
(Parent or guardian if under 18)