Adelaide Family Dental

Dernancourt | Melbourne St | Glandore

www.adelaidefamilydental.com.au

A. Personal Details

Surname:		Given Names:	
Date of Birth:		Occupation:	
Phone Number: Home ☐ Work ☐ Mobile ☐ (Please tick the box of the number you prefer we contact you on)		Home Address:	
Email Address:			
Health Fund:		Member Number:	Series Number:
Emergency Contact	Full Name: Phone Number: Relation:		
Approx. Weight: (in Kg)		Approx. Height: (in cm)	BMI: (Calculator)

B. Medical History

				If you answer **YES**, please provide further details:
Have you ever experienced any adverse or allergic reactions to:	Medications?	Y	N	
	Foods? (eg. nuts, lactose, gluten)	Y	N	
	Other? (pollen, animals)	Y	N	
Are there analgesics you don't like to take?		Y	N	
Have you ever had high blood pressure?		Y	N	
Have you ever had heart surgery?	Prosthetic heart valve?	Y	N	
	Pacemaker?	Y	N	
Have you been diagnosed with other heart problems or conditions?	Irregular heartbeat/Tachycardia?	Y	N	
	Heart attack?	Y	N	
	Heart Failure?	Y	N	
	Excessive bleeding problems?	Y	N	
Have you ever been diagnosed or experienced the following?	Strokes?	Y	N	
	Asthma?	Y	N	
	Emphysema? Or lung diseases?	Y	N	
	Epilepsy?	Y	N	
	Kidney Issues?	Y	N	
	Liver Issues?	Y	N	
	Psychiatric Problems?	Y	N	
	Bloodborne diseases? HIV/AIDS? Hep A/B/C?	Y	N	
	Arthritis? Type?	Y	N	
	Diabetes? Type?	Y	N	

Are you currently pregnant? If yes please specify how many weeks	Y	N	
Have you been diagnosed with a disability? Or are you a special needs?	Y	N	
Do you suffer from reflux, heartburn or vomiting?	Y	N	
Have you ever undergone radiation or chemotherapy? Specify type of cancer	Y	N	
Have you ever had joint replacement therapy?	Y	N	
Do you take any blood thinners (eg. Aspirin, Warfarin, Clopidogrel, Apixaban, Xarelto and fish oil)? If yes please specify	Y	N	
Do you take any medication for osteoporosis (Prolia, Fosamax, Actonel and Boniva)? If yes please specify	Y	N	
Please list in the box below all medications you regularly take (prescription, non-prescription, herbal and/or alternative medicines)			

C. Dental History	If you answer **YES**, please provide further details:		
Do you have a dental or needle phobia?	Y	N	
Do you suffer from a gag reflex?	Y	N	
Do you have any caps, crowns or dentures?	Y	N	
When was the last time you visited the dentist?			
D. Social History	If you answer **YES**, please provide further details:		
Do you smoke or vape? If yes how many per day	Y	N	
Do you drink alcohol? If yes please circle	Y	N	Heavy / Social / Non-Drinker
Do you take any recreational drugs?	Y	N	
E. Anaesthetics History	If you answer **YES**, please provide further details:		
Have you ever had IV Sedation or General Anaesthesia/GA before?	Y	N	
Have you had any adverse reactions to IV Sedation or General Anaesthesia?	Y	N	
Have you had any blood relatives with problems to IV/GA?	Y	N	
Have you been diagnosed with sleep apnoea? Do you use a CPAP machine?	Y	N	

Referral Information

☐ Internet/Website ☐ Walked past ☐ Village Voice ☐ Other

☐ Patient (Please provide their name so we can thank them) _____

Consent for services

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires at least 24 hours' notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 could be incurred if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment.

We provide as a courtesy to our patients a preventative recall program that offers a call service if you have not been to the practice in 6 months. Do you wish to receive a phone call from the practice in the event that you have missed your recall? ☐ Yes ☐ No

Signature: _____ Date of signature: _____