

**PATIENT HISTORY SHEET**

**COBURG DENTAL GROUP  
127 SYDNEY ROAD COBURG 3058 Phone 9386 1805**

**Welcome to our practice. To assist in determining your treatment please answer the following questions as accurately as possible. All information will be held in confidence according to our privacy policy.**

TITLE Mr / Mrs / Miss / Ms / Dr / Other \_\_\_\_\_ SURNAME \_\_\_\_\_  
GIVEN NAMES \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SUBURB \_\_\_\_\_ POSTCODE \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ COMPANY NAME \_\_\_\_\_  
WORK ADDRESS \_\_\_\_\_ SUBURB \_\_\_\_\_ POSTCODE \_\_\_\_\_  
HOME TELEPHONE \_\_\_\_\_ WORK TELEPHONE \_\_\_\_\_  
MOBILE TELEPHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_  
NAME OF PERSON RESPONSIBLE FOR FEES \_\_\_\_\_  
DO YOU HAVE DENTAL INSURANCE? YES NO IF YES, WHICH FUND? \_\_\_\_\_

**IN CASE OF EMERGENCY (outside of immediate household)**

FIRST NAME \_\_\_\_\_ SURNAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SUBURB \_\_\_\_\_ POSTCODE \_\_\_\_\_  
CONTACT NUMBERS (AH) \_\_\_\_\_ MOBILE \_\_\_\_\_

**MEDICAL HISTORY**

RHEUMATIC FEVER	YES / NO	BLEEDING DISORDER	YES / NO
EPILEPSY	YES / NO	AIDS / HIV	YES / NO
ASTHMA	YES / NO	HEART AILMENT	YES / NO
TUBERCULOSIS	YES / NO	HIGH BLOOD PRESSURE	YES / NO
DIABETES	YES / NO	HEPATITIS A,B OR C	YES / NO
KIDNEY DISEASE	YES / NO	CREUTZFELDT JAKOB DISEASE	YES / NO
DEPRESSION	YES / NO	CANCER	YES / NO
SNORING/ SLEEP DISORDER	YES / NO	OTHER ILLNESS NEEDING HOSPITALISATION	YES / NO

List any allergies (eg drugs, medicine or latex) \_\_\_\_\_

Do you have an artificial hip, heart valve or other prosthetic implant? \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

If female, are you pregnant YES NO MAYBE

Are you under a physicians care? YES NO If yes, why? \_\_\_\_\_

Do you smoke or use tobacco? YES NO

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

**I also understand that PAYMENT is required on the day of treatment unless otherwise arranged**

Signed \_\_\_\_\_ Date \_\_\_\_\_ Checked(Dr) \_\_\_\_\_

**ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED**