INGLEBURN DENTAL File no. (Office use only)

Surname:______________________________ Given Name: ______________________________
(Block Letters) (Block Letters)

Address:____

Suburb: ______________________________ P/code:________ Date of Birth: ___/___/___

Phone: (Home)____________________ (Mobile)______________________________

(Work) ____________________ Email______________________________

Dental Extras Health Fund: ☐ Yes ☐ No Name of fund:______________________________

Please circle the matching number on the Health Fund Card: 0 1 2 3 4 5 6

Health Fund cards are required each visit for electronic rebate processing

Ever had any allergies? (e.g. Penicillin, Sulphur, Milk, Latex, Metal) ☐ Yes ☐ No

If yes, which ones?______________________________

Medical History

Ever had or suffer from any following:

If YES please circle each one

Heart Attack, Heart Disorder, Blood or Bleeding Disorders, Asthma, Breathing Difficulty, Repeated Fainting, Epilepsy, Immune Disorders, Arthritis, Infectious Diseases, Lupus, Tuberculosis, Kidney Disease, Diabetes, Liver Dysfunction, Hepatitis

If NO Tick ☐

Recent Medical Conditions

If YES please circle each one

Cold Sores, Measles, Mumps, Cancer,
Severe Cough, Flu, Joint Replacement

If NO Tick ☐

Medical Treatment History

Ever had any of the following:

If YES please circle each one

Major Heart Surgery, Adverse Drug Reaction, Radiotherapy and or Chemotherapy, Osteoporosis Medication (see list below) or Long-term Anticoagulant Medication

If NO Tick ☐

Dental Concerns **Please circle each one**

Grinding teeth (night), Mouth Breathing (night), Snoring, Reflux, Dry Mouth, Bad Breath, Loose Teeth, Frequent Mouth Ulcers, Clicking or Pain in Jaw, Difficult Extractions

If circled Yes to any of the above Medical Concerns, please provide further details:

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If Serious Medical Concerns, please provide Medical Practitioners name and contact below

Doctor's Name:______________________________ Contact:______________________________

If taking any of these medications**, please circle** which ones

Osteoporosis: Actonel, Bonviva, Bonefos, Didronel, Fosamax, Skelid,
Prolia, Aredia, Pamisol, Zometa, Aclasta, Other

Anticoagulant: Warfarin, Apixaban (Eliquis) Rivaroxaban (Xarelto),
Dabigatran (Pradaxa), Clopidogrel (Plavix), Other

Please List any Other Regular Medications______________________________

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Expectant Mothers due date:______________________________

Note: Fee charges: cancellation within 24 hours $30. Non-attendance $45

Payment required at each appointment. Preferred method of payment **please circle**:

CASH EFTPOS MASTERCARD VISA AMEX

PATIENT (parent/Guardian) SIGNATURE______________________________ DATE:____________________

Your signature states that all above details are correct and that your treatment records may be shared with appropriate professionals