It is important for us to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy which is shown on the reverse of this form.

Name First: Mr./Mrs/Miss/Ms .... Middle: .... Last:.....................................

Address:.. Suburb & Postcode ....

Phone (Home):... Phone (Mobile):...

Email:..

Date of Birth:.. Gender: ☐ Male ☐ Female

Emergency Contact Name:...................................... **Relationship:**.................................... **Phone:**............................

Name of Dental Health Insurance:...

Who referred you to our practice? (Signage / Internet / Word of Mouth / Doctor or Dentist) ....

Contact details of your doctor: ....

When was your last dental visit? ....

What was your concern with previous dental visits?...

Do you normally require antibiotic cover before dental treatment?	Yes	No
Have you had any abnormal reaction to local or general anaesthesia?	Yes	No
Have you been hospitalised in the last 12 months?	Yes	No
Are you pregnant or lactating? (Females only)	Yes	No
Do you smoke	Yes	No

Please tick (✓) if you have or ever had any of the following medical conditions?

Rheumatic Fever		Diabetes	
Epilepsy		Kidney Disease	
Radiation/Chemotherapy		Excessive Bleeding	
Stroke		Bone Disease Including Osteoporosis	
Heart Valve Disorder		Anaemia or Blood Disorder	
Heart Complaint/ Heart Surgery		Hepatitis or Liver Disease	
Cardiac Pacemaker		Steroid Therapy	
High or Low Blood Pressure		Stomach or Digestive Condition (reflux)	
Cholesterol		Arthritis	
Asthma		Prosthetic Implant (eg: Hip or Knee)	
Tuberculosis		Nervous or Psychiatric Condition	
Bronchitis, Emphysema, or other Lung Disease			

Any other condition (not mentioned earlier) or comments: ....
....

List allergies if any (eg: nuts, fish, medications, etc):..

List any medications or supplements (prescribed or over the counter) ....

How will you be paying today ....

I have read and accepted the privacy policy on the reverse of this form. I understand that it is my responsibility to pay for all non covered services, co-insurance, co-payments and deductibles on the day services are rendered.

Your/Guardian's Signature .... Date:.....................................

Springs Dental Group

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