PELAGO DENTAL

"Honest, professional dental care"

Dr Kathryn Randall BDSc (Hons) UWA

182/26 Sharpe Avenue, KARRATHA WA 6714

Phone (08) 9185 4849

PATIENT DETAILS

Name _____ _____

(Title) (First name) (Family name)

Preferred Name _____ Date of Birth _____ Sex M ☐ F ☐

Address_____

_____Postcode_____

Phone: M_____ H_____ W_____ Email:_____

Occupation: _____

Emergency contact:_____ Relationship:_____ Phone: _____

Person responsible for payment of accounts (if not self): _____

Which Health Fund do you belong to? _____ Member Number _____Ref _____

Is there another family member who visits our practice? _____

How did you find us or who may we thank for recommending you to our practice? _____

MEDICAL HISTORY

Do you have or have you ever had any of the following:

	Y	N		Y	N
Heart problems	☐	☐	Epilepsy (fits)	☐	☐
Congenital heart disease	☐	☐	Stroke	☐	☐
Previous Infective Endocarditis	☐	☐	Thyroid disease (including goitre)	☐	☐
Heart attack	☐	☐	Tuberculosis (TB)	☐	☐
Mitral valve prolapse	☐	☐	Asthma or Breathing Problems	☐	☐
Cardiac Pacemaker	☐	☐	Neurological disorders	☐	☐
Artificial heart valve	☐	☐	Anxiety depression	☐	☐
High blood pressure	☐	☐	Gastroesophageal reflux disease (GORD)	☐	☐
Blood disorders	☐	☐	Inflammatory bowel disease	☐	☐
Excessive bruising or bleeding	☐	☐	Chemotherapy / Radiotherapy	☐	☐
Osteoporosis (low bone density)	☐	☐	Treatment for cancer	☐	☐
Diabetes (☐ Type1 ☐Type 2)	☐	☐	Allergies	☐	☐
HIV or AIDS	☐	☐	Organ, stem cell or bone marrow transplant	☐	☐
Hepatitis A B C, other liver disease	☐	☐	Arthritis	☐	☐
Urinary tract or kidney disease	☐	☐	Sinus trouble	☐	☐
Artificial joint	☐	☐	Snoring or sleep apnoea	☐	☐

Please provide details of any medical condition not listed or details of any condition you ticked "yes" to:

_____

_____

_____

Name of Medical Doctor: _____ Practice: _____ Ph: _____

Please list any **medications,** pills, supplements or over the counter medications that you may be taking:_____

_____

_____

Do you have any allergies to:

☐ Latex ☐ Acrylic ☐ Chlorhexidine

☐ Codeine ☐ Penicillin ☐ Other_____

Any other medications you are unable to take? _____

Do smoke? ☐ No ☐ No, I quit. When? _____ ☐ Yes For how long?_____ How many? _____

Have you ever had Botox or Fillers? ☐ Yes ☐ No Was this within the past two weeks? ☐ Yes ☐ No

FEMALES:

Are you pregnant ☐ No ☐ Yes When are you due?_____

Are you breastfeeding ☐ No ☐ Yes

DENTAL HISTORY

How do you feel about visits to the dentist?

☐ Love them ☐ Not fussed ☐ A little apprehensive ☐ Anxious ☐ Extremely nervous

When did you last visit the dentist? Have you or are you whitening your teeth? ☐ Yes ☐ No

What do you currently do to look after your teeth at home? (Brush, floss, rinse, how often, electric or manual brush)_____

Type of toothpaste: ☐ Regular ☐ Whitening ☐ Sensitive ☐ Other

Previous dental x-rays taken how long ago?_____

Have you had any of the following?

☐ Sore jaw, clenching, grinding teeth
☐ Clicking/popping jaw
☐ Wear a night guard/splint
☐ Orthodontic treatment (braces)
☐ Gum disease
☐ Bad breath
☐ High blood pressure
☐ Bleeding gums
☐ Sensitivity to hot/cold
☐ Floss tearing between teeth
☐ Food packing between teeth
☐ Teeth hurt when you bite
☐ Need extra anaesthetic to go numb
☐ Dry mouth

DECLARATION

In signing this form I acknowledge that this represents an accurate medical history and I will advise of any changes to my medical history in the future. I understand all medical details will be treated with complete professional confidentiality. I have read the privacy document provided by this practice.

Payment is required on the day of treatment. In the event of an account being in default the customer shall be liable for all resulting costs arising from the recovery, which includes the account in full and legal costs including demand costs. Full trading terms and privacy statement are available on our website, or a copy may be provided by reception upon request.

*Signed*_____ *Date* _____

(parent or guardian if under 18 years of age)