Title: \_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_\_

Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Next of Kin Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctors Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Currently Taking Any Medications? **YES/NO.** If **YES** Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Taking Osteoporosis Medications (e.g. Actonel, Fosamax, Bisphosphonates)? **YES/NO.**

If **YES** Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Taking Blood Thinning Medications? **YES/NO**

If Yes, please specify: (Warfarin/ Marevan/ Aspirin/ Coumadin/ Aredia/ Zometa) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Pregnant? **YES/NO.** If **YES**, How Many Weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have You Had Any of the Following? (Please Circle)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heart Problems. If Yes, Please Specify: | Yes | No | Allergies to Anaesthetic. If Yes, Please Specify: | Yes | No |
| Blood Pressure Problems: High/Low | Yes | No | Allergies to Penicillin | Yes | No |
| Artificial Joints:  Date of Surgery: | Yes | No | Allergies to Medications: If Yes, Please Specify: | Yes | No |
| Rheumatic Fever: Year: | Yes | No | Allergies to Latex | Yes | No |
| Circulatory Problems | Yes | No | Other Allergies: Please Specify: | Yes | No |
| Chemotherapy/Radiotherapy | Yes | No | Arthritis | Yes | No |
| Cancer Head/Neck | Yes | No | Diabetes: Type: | Yes | No |
| Excessive Bleeding | Yes | No | Asthma | Yes | No |
| Excessive Bruising | Yes | No | Hepatitis A B or C: Year: | Yes | No |
| Stomach Ulcers | Yes | No | Epilepsy | Yes | No |
| Sinus Problems | Yes | No | Psychiatric Condition | Yes | No |
| Osteoporosis. If yes, please specify medications:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No | Anaemia or Other Blood Disorders: If yes, please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No |
| HIV | Yes | No | Liver or Kidney Problems | Yes | No |

**Consent for Treatment:**

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives, and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payments of all services unless other arrangements have been made. I authorise that this data may be reviewed by team members of this dental practice.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_