Apple Dental
104 Breakfast Creek Road, Newstead 4006
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Email: info@apple-dental.com.au

It is a legal requirement that we request patients update medical information every 12 months.

Medical History

In order to render dental treatment of a high standard, it is necessary to have the following information which will be handled confidentially. Please fill in this form completely.

DR / MR / MRS / MS / Miss / Master (please circle)

NAME: (in full)……D.O.B……

ADDRESS……

POSTAL ADDRESS ……

TELEPHONE: (private) …….. (business) ……

(mobile) ……

EMAIL ADDRESS……

DENTAL HEALTH FUND ……

HOW DID YOU FIND OUT ABOUT THIS PRACTICE .....
(if a friend has referred you please supply their name so we can thank them)

☐ Health Fund ☐ Magazine ☐ Mail out

☐ Internet ☐ Friends ☐ Other

DO YOU WORK FOR

☐ Energex ☐ Remserve ☐ BOQ

MEDICAL AND DENTAL HISTORY

When was your last dental visit and what procedure did you have…… ….

Are you currently taking any Medication (**please list**)……

Do you have any allergies to medicines or drugs (**please list**).....

Please indicate below if you have had, or have at present, any of the following:

High/Low Blood Pressure	Yes / No	Epilepsy	Yes / No
Artificial Joint	Yes / No	Rheumatic Fever	Yes / No
Diabetes	Yes / No	Thyroid Disease	Yes / No
Heart Complaint/Chest Pain	Yes / No	Stroke	Yes / No
Chemotherapy	Yes / No	Steroid Therapy	Yes / No
Radiation Therapy	Yes / No	Bleeding Disorder	Yes / No
Cardiac Pacemaker	Yes / No	Emphysema	Yes / No
Contact with HIV / AIDS	Yes / No	Hepatitis A, B or C	Yes / No
Other Liver Disease	Yes / No	Tuberculosis	Yes / No
Kidney Disease	Yes / No	Transplanted Organ or Marrow	Yes / No
Osteoporosis	Yes / No	Are you pregnant (females only)	Yes / No
Asthma	Yes / No		

Are you required to take antibiotics before any invasive dental procedures? Yes / No

Do you Smoke? Yes / No

How would you like to be contacted for confirmation? ☐ Text ☐ Email ☐ Courtesy call

SIGNATURE: _____ Date: _____