LYGON FAMIY DENTAL
137 LYGON STREET, BRUNSWICK EAST 3057 Phone: (03)9939 0323

NEW PATIENT HISTORY SHEET

Welcome to our practice. To assist in determining your treatment please answer the following questions as accurately as possible. All information will be held in confidence according to our privacy policy.

TITLE: Mr/Mrs/Miss/Ms/Dr/Other_____**SURNAME**_____

GIVEN NAMES_____ **BIRTH DATE** _____

ADDRESS_____**SUBURB**_____**POSTCODE**_____

OCCUPATION_____**COMPANY NAME**_____

WORK ADDRESS_____**SUBURB**_____**POSTCODE**_____

HOME TELEPHONE_____**EMAIL**_____

MOBILE TELEPHONE_____**WORK TELEPHONE**_____

WHOME MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

NAME OF PERSON RESPONSIBLE FOR FEES_____

DO YOU HAVE DENTAL INSURANCE: YES NO IF YES, WHICH FUND? _____

WHEN DID YOU SEE A DENTIST LAST TIME: _____/_____/_____

IN CASE OF EMERGENCY (OUTSIDE OF IMMEDIATE HOUSEHOLD)

FIRST NAME_____**SURNAME**_____

ADDRESS_____**SUBURB**_____**POSTCODE**_____

CONTACT NUMBERS (AH)_____**MOBILE**_____

MEDICAL HISTORY

RHEUMATIC FEVER	**YES / NO**	**BLEEDING DISORDER**	**YES / NO**
EPILEPSY	**YES / NO**	**AIDS/HIV**	**YES / NO**
ASTHMA	**YES / NO**	**HEART AILMENT**	**YES / NO**
TUBERCULOSIS	**YES / NO**	**HIGH BLOOD PRESSURE**	**YES / NO**
DIABETES	**YES / NO**	**HEPATITIS A,B OR C**	**YES / NO**
KIDNEY DISEASE	**YES / NO**	**CREUTZFELDT JAKOB DISEASE**	**YES / NO**
DEPRESSION	**YES / NO**	**CANCER**	**YES / NO**
SNORING/SLEEP DISORDER	**YES / NO**	**OTHER ILLNESS NEEDING HOSPITALISATION**	**YES / NO**

LIST ANY ALLERGIES (e.g. drugs, medicine or latex) _____

Do you have any artificial hip, heart valve or other prosthetic implant_____**?**

List any medications you are taking _____

If female, are you pregnant? YES NO MAYBE

Are you under a physician's care? YES NO MAYBE

Do you smoke or use tobacco YES NO MAYBE

I have completed this questionnaire to the best of my knowledge and understand that failure to make full disclosure may place me at undue medical risk.
I also understand that PAYMENT is required on the day of treatment unless otherwise arranged.

Signed _____**DATE** _____**CHECKED (DR.)** _____