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: CONTACT NAME_____ NUMBER _____

DENTAL HISTORY

DENTAL CHIEF CONCERNS _____

BRUSHING: ONCE A DAY_____ TWICE A DAY_____ ONCE A WEEK_____ ONLY MORNINGS_____ ONLY NIGHTS_____

FLOSSING: ONCE A DAY_____ TWICE A DAY_____ ONCE A WEEK_____ RARELY_____ NEVER _____

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/GRINDING	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 taking any bone medication: PROLIA or Equivalent ?	YES	NO	MAYBE
Do you smoke or use tobacco?	YES	NO	OCCASIONALLY
Any knee or hip replacement surgery in the last 3-6 months?	YES	NO	< 6 MONTHS AGO

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.) _____