BEACHES DENTAL
MONA VALE

PATIENT INFORMATION FORM

Title: ..... Surname: ..... Given Names: .....

Gender: Male □ Female □ Non-binary □ Prefer not to say □

Date of Birth: ..... Email: .....

Address: ..... Suburb: ..... Postcode: .....

Mobile: ..... Phone: ..... Occupation: .....

Emergency Contact Name: ..... Emergency Contact Phone: .....

Do you have health fund cover for dental: □ Yes □ No Do you have a Veterans Affairs card: □ Yes □ No

Name of current GP/Practice: ..... Phone: .....

How did you hear about us? □ Doctor □ Internet Search □ Location □ Friend/Family □ Other .....

How long since your last dental visit: □ less than 12 months □ 1 - 2 years □ 2 - 5 years □ over 5 years

How do you rate your dental health: □ Excellent □ Good □ Fair □ Poor

Is there anything about your smile you would like to change? .....

MEDICAL HISTORY ALL INFORMATION COLLECTED IS CONFIDENTIAL AND USED ONLY FOR YOUR DENTAL CARE

Do you have any allergies? (eg: Latex, penicillin etc) □ Yes □ No
If yes, please list .....

Have you been hospitalised in the last 2 years? □ Yes □ No
If yes, please list .....

Do you have a heart condition? □ Yes □ No
If yes, please list .....

Do you bleed or bruise easily? □ Yes □ No Do you take an anti-coagulant medication? □ Yes □ No
Do you smoke or vape? □ Yes □ No If yes, how many per day? .....
Do you drink alcohol? □ Yes □ No If yes, how many standard drinks per week? .....
Are you currently pregnant? □ Yes □ No Are you currently breastfeeding? □ Yes □ No
Have you ever taken Bisphosphenates (eg: Actenol) or Monoclonal Antibodies (eg: Prolia) □ Yes □ No
Do you take any medications? □ Yes □ No If yes, please list below:

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Please tick if you have or have had any of the below medical conditions:

□ Heart attack	□ High blood pressure	□ Cancer	□ Reflux
□ Heart disease/stent placed	□ Low blood pressure	□ Chemotherapy	□ Diabetes
□ Heart murmur	□ Anaemia	□ Radiation	□ Kidney disease
□ Heart valve replacement	□ High cholesterol	□ Immune suppression	□ Thyroid disease
□ Pacemaker	□ Rheumatic fever	□ Organ transplant	□ Arthritis
□ Angina/Chest pains	□ COPD	□ Mental Illness	□ Joint Replacement
□ Palpitations	□ Sleep apnoea	□ Anxiety/Depression	□ Osteoporosis
□ Bleeding disorder	□ Sinusitis	□ Epilepsy	□ Hepatitis
□ Stroke	□ Asthma	□ ADHD/Autism/Aspergers	□ Liver disease

Any illness not listed above .....

I believe the above information to be true & correct

SIGNED: ..... *DATE:* .....