charlestown dentalcare

Miss/ Mrs/ Ms/ Mr/ Dr

NAME.....(preferred).....

ADDRESS.....

..... **POSTCODE**.....

PHONE-(Private)..... (Business)..... (Mobile).....

DATE OF BIRTH- .....**PARENTS NAME**- (if under 18yrs).....

PLACE OF EMPLOYMENT- .....

ARE YOU IN A PRIVATE HEALTH FUND? (if "yes" please name the fund)

.....

Have been treated for any of the following- (please circle)

- A heart condition YES/NO
- High/low blood pressure YES/NO
- Diabetes YES/NO
- Epilepsy YES/NO
- Asthma YES/NO

Have you ever had a history of- (please circle)

A heart murmur YES/NO
-Rheumatic fever YES/NO
-Gastric reflux YES/NO
-Stomach ulcers YES/NO
-Thyroid condition YES/NO
-Prolonged bleeding from injury or tooth extraction YES/NO
-Difficultly after a tooth extraction YES/NO

Have you ever had-

- Deep ray treatment to your head or neck? YES/NO
-A reaction to local anaesthetic? YES/NO

Are you allergic to any medications? (if "yes" please list) YES/NO

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Are you currently under care of a specialist? (if "yes" please list) YES/NO

.....

Are you currently taking any medications? (if "yes" please list) YES/NO

.....

Name of your general practitioner- .....

How did you hear about Charlestown Dental Care? .....

SIGNATURE- .....**DATE**- .....

Suite 6, 20 Smith Street (PO Box 101) Charlestown NSW 2290
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