28 Paxton Street,
North Ward Q4810

tel: 07 4772 4944
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info@dentistonpaxton.com

CONFIDENTIAL PATIENT INFORMATION

This provides the dentist with important information required for your Dental treatment and Oral Health Care.

Name: ____

Surname First Names Dr / Mr / Mrs / Miss / Ms

Postal Address: ____

____

Home Address: ____

____

Date of Birth: ____________________ Email Address: ____________________

Home Phone: ____________________ Occupation: ____________________

Mobile: ____________________ Work Phone: ____________________

Work Address: ____

____

Are you covered for dental treatment in a Private Health Fund? ____________________

Details of person to contact in an emergency:

Name: ____________________ Phone Number: ____________________

MEDICAL HISTORY

Please CIRCLE YES / NO Below

Medical Doctor's (GP) Name: ____________________ Phone (If known): ____________________

1. Are you receiving any medical treatment at the present time? Yes / No

   Details: ____

2. Are you taking any medication at present, if so, please list? Yes / No

   Details: ____

3. Have you experienced any allergies or unusual effects from any tablets, drugs, injections or anaesthetic? Yes / No

   Details: ____

4. Have you had any prosthetic surgery? If yes, when? Yes / No

   (Eg. Heart Valve or Hip Replacement)

   Details: ____

5. Do you require antibiotic cover before treatment? Yes / No

   Details: ____________________

6. (Females) Are you pregnant? Yes / No

   Expected due date: ____________________

7. Have you ever had any of the following? If so, please TICK as appropriate.

☐ Rheumatic Fever	☐ Heart Trouble	☐ High Blood Pressure
☐ Epilepsy	☐ Asthma	☐ Diabetes
☐ Cold Sores	☐ Drug Dependence	☐ Bronchitis / Chest Problems
☐ Hepatitis A, B, C	☐ HIV	☐ Other

DENTAL HISTORY

1. Name of Last Dentist and date of last visit: ____________________
2. Do you have Dental pain or a Dental problem at present? Yes / No

   Details: ____________________

3. Have you ever experienced excessive bleeding or bruising from dental treatment/cuts/scratches? Yes / No
4. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Referred By:

☐ Yellow Pages ☐ Street Sign ☐ Patient/Friend ____________ Other ____________

****Treatment is to be paid for on the day of your visit****

A fee will be charged for broken appointments and late cancellations (less than 24 hours notice)

Signature: ____________________ Patient / Parent / Guardian

Date: ____________