

BUDI DENTAL

Suite 4 Ballinger Place, 3-5 Ballinger Road, Buderim QLD 4556

Initial Dental and Medical History

*Welcome! So that we may provide you with the best possible care, please complete this Dental / Medical History form.
Please be assured that all information is completely confidential.*

TITLE:		FIRST NAME:		LAST NAME:	
DOB:		HEALTH FUND:	Yes / No	NAME OF FUND:	
RESIDENTIAL ADDRESS:				SUBURB:	
POSTAL ADDRESS (if different to above):				SUBURB:	
HOME PHONE:		MOBILE:		WORK:	
EMAIL:				OCCUPATION:	
PREFERRED METHOD OF CONTACT:	Home phone / mobile / work / email			Women: are you pregnant?	Yes / No
EMERGENCY CONTACT NAME:				PHONE:	
MEDICAL PRACTITIONER NAME:				PHONE:	

- Are you taking any medications, drugs or pills? **Yes / No** If yes, please list names: _____
- Please list any known allergies (medications, penicillin, latex, etc.) _____
- Have you had any abnormal reactions to local or general anaesthetic? **Yes / No** Details: _____
- Do you normally require antibiotic cover before dental treatment? **Yes / No** If yes, why? _____
- Below:** indicate which of the following you have had, or have at present. *Tick "yes" or "no" to each item.*

	YES	NO		YES	NO
Congenital Heart Disease			Transplanted Marrow		
Heart Murmur			Arthritis / Rheumatism		
Mitral Valve Prolapse			Stroke		
Heart Pacemaker			Artificial joints		
Tuberculosis			Epilepsy / Seizures		
Rheumatic Fever			Diabetes		
High Blood Pressure			Hepatitis / HIV		
Radiation Therapy			Cancer		
Liver Disease			Asthma		
Leukaemia			Sinus trouble		

Dentist Comments only: _____

- Please list any concerns or problems you have with your teeth or mouth: _____

How did you hear about us:

- Internet
 Street Sign
 Word of mouth
 Health Fund
 Budi Bulletin
 Another patient: (name)
 Other:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be required, you have my permission to ask the respective health care provider, who may release such information to you.

Patient / Guardian Signature: _____

Date: _____

OFFICE USE ONLY	
Provider:	Reception: