4 Hardey Road Glen Forrest WA 6071
Tel: 9298 8187 Fax: 9298 9661
Email: info@glenforrestdental.com.au
Website: www.glenforrestdental.com.au

Name: ____________________________ Preferred Name: ____________________

Postal Address: ____________________________ Date of Birth: ____________________

____________________________ Mobile: ____________________

Email : ____________________________ Home Phone: ____________________

What is your occupation? ____________________ Work Phone: ____________________

Person responsible for your account? ____________________ Sign: ____________________

Do you have health insurance for Dental? **NO / YES, f**und name & number: ____________________

Who is your medical Doctor? ____________________ Phone: ____________________

Emergency contact? ____________ Relationship: ____________ Phone: ____________

When was your last dental visit?____________Reason for your visit today? ____________________

How do you feel about visiting the dentist? (Mark **X** on the line) Calm--- Tense

Do you have injections for dental treatment? ALWAYS NEVER SOMETIMES ASK ME FIRST

Have you ever had a problem with injections? **YES / NO** Details: ____________________

Local Anaesthesia may cause nerve damage, if it happens, is usually temporary, and will get better over a period of weeks to months. Damage may cause weakness and/or numbness of the body part that the nerve goes to. Permanent nerve damage rarely happens. Other side effects are: bruising, infection, needle breaks, failure of anaesthesia, seizures and cardiac arrest.

Are you taking any medications? **YES / NO** Details:____________________________

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Medical History	**Never**	**Past**	**Present**	**Details**
Had a bad reaction to medication				
Allergies/Hypersensitivities eg: Latex				
Suffer from asthma				
Blood pressure –high or low				
Blood/bleeding disorder				
Heart conditions/problems				
Pacemaker/Prosthetic heart valves				
Rheumatic fever				
Prosthetic implants (eg: hips/knees)				
Have diabetes				
Epilepsy				
Gastric acid reflux				
Osteoporosis				
HIV or hepatitis				
Do you smoke				
Other conditions				
Females - Are you pregnant	Yes	No	Unsure	

<u>ALL INFORMATION IS CONFIDENTIAL</u>

Sign: ____________________________ Date: ____________________

Has any of your contact details, address, medication or medical history changed in the last 6 months? **YES / NO**
If yes, please state below:

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Sign: ________________________________ Date:________________________________

Has any of your contact details, address, medication or medical history changed in the last 6 months? **YES / NO**
If yes, please state below:

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Sign: ________________________________ Date: ________________________________

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Sign: ________________________________ Date: ________________________________