LYGON FAMIY DENTAL 137 LYGON STREET, BRUNSWICK EAST 3057 Phone: (03)9939 0323

NEW PATIENT HISTORY SHEET

Welcome to our practice. To assist in determining your treatment please answer the following questions as accurately as possible. All information will be held in confidence according to our privacy policy.

TITLE: Mr/Mrs/Miss/Ms/Dr/OtherS			URNAME				
GIVEN NAMES E			IRTH DATE				
ADDRESSS			GUBURBPOSTCODE				
OCCUPATION		COMPANY	NAME_				
WORK ADDRESSS			UBURB POSTCODE				
HOME TELEPHONEE							
MOBILE TELEPHONEW							
WHOME MAY WE THANK FO	OR REFERRING YOU TO OUR	OFFICE?					
NAME OF PERSON RESPONS	SIBLE FOR FEES						
DO YOU HAVE DENTAL INSURANCE: YES NO			IF YES, WHICH FUND?				
WHEN DID YOU SEE A DENT	TIST LAST TIME:	/	/				
IN CASE OF EMERGENCY: CONTACT NAME			NUMBER				
	DENTA	AL HISTOR	RY				
DENTAL CHIEF CONCERNS							
	TWICE A DAY ONC				ONLY NICI	———— итс	
FLUSSING: UNCE A DAY	TWICE A DAY C			RARELY	NEVER		
	MEDIC	AL HISTO	RY				
RHEUMATIC FEVER	YES / NO	BLEEDING DISORDER				YES / NO	
EPILEPSY	YES / NO	AIDS/HIV				YES / NO	
ASTHMA	YES / NO	HEART AILMENT YES / N					
TUBERCULOSIS	YES / NO	HIGH BLOOD PRESSURE YES / NO					
DIABETES	YES / NO	HEPATITIS A, B OR C YES / NO					
KIDNEY DISEASE	YES / NO	CREUTZFELDT JAKOB DISEASE YES / NO					
DEPRESSION	YES / NO	CANCER YES / NO					
SNORING/ <u>GRINDING</u>	YES / NO	OTHER ILLNESS NEEDING HOSPITALISATION YES / NO					
LIST ANY ALLERGIES (e.g. d	rugs, medicine or latex)						
Do you have any artificial h	ip, heart valve or other prost	thetic implant	t?				
List any medications you ar	e taking						
If female, are you pregnant?			YES	NO	MAYBE		
Are you taking any bone medication: PROLIA or Equivalent?			YES	NO	MAYBE		
Do you smoke or use tobacco?			YES	NO	OCCASIONA	ALLY	
Any knee or hip replacement surgery in the last 3-6 months?			YES	NO	< 6 MONTH	< 6 MONTHS AGO	
I have completed this que	stionnaire to the best of my k	_			ıre to make full (disclosure	
I also understan	may place me a nd that PAYMENT is required				rwise arranged.		
	-	-			-		

_____DATE _____CHECKED (DR.) ____