ALBANY DENTAL your family dentists	Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐	Surname:	Given Names:
Date of birth:	Phone (H):	Phone (M):	Email:
Address:			
Medicare No:	Emergency Contact Name: Phone: Relationship:		
If patient is under 16 years of age - Guardian Name: Phone:			
Name of your GP:		GP's Phone:	GP's Suburb:
Last dental visit:		Referred by (name):	

Please tick yes or no to the following questions, and list any medication
Do you have or have ever had the following:

CONDITION	YES	NO	MEDICATION NAME
Allergies (e.g. Antibiotics, bees, latex)			
Pregnant? If so how many weeks?			
Smoker? If so how many a day?			
Heart Disease			
High Blood Pressure			
Low Blood Pressure			
Heart Valve Replacement			
Pacemaker/Defibrillator			
Infective Endocarditis			
Rheumatic Fever			
Stroke			
Epilepsy			
Anaemia			
Excessive Bleeding/Bruising			
Liver Disease			
Hepatitis A, B or C			
HIV/AIDS			
Diabetes			
Thyroid Disorder			
Kidney Problems			
Osteoporosis			
Surgical Prosthesis/Joint Replacement			
Arthritis			
Reflux/Heartburn/GORD			
Respiratory Problems			
Sinus Problems			
Asthma			
Sleep Apnoea			
Tuberculosis			
Cancer			
Radiation/Chemo Therapy			
Stress/Anxiety/Phobias/Depression			
Physical Disabilities			
Dry Mouth			
Operations/Surgery in the last 2 years			
Anything else not listed here:			
Is there anything you are concerned with? (e.g. cosmetic appearance, grinding, food trap, snoring)			