WOOLOOWARE DENTAL

Welcome to Woolooware Dental, please fill out your details carefully.

Mr / Mrs / Ms

First Name ______________________ Surname ______________________

Address ____

______________________ Postcode ______________________

Phone H______________ W______________ M______________

Email ____

Date of Birth ____

Who referred you to this practice? ______________________

MEDICAL HISTORY
Have you ever had or are you suffering from:

- ☐ AIDS
- ☐ Allergies
- ☐ Anaemia
- ☐ Asthma
- ☐ High/Low blood pressure
- ☐ Diabetes
- ☐ Excessive bleeding
- ☐ Heart complaints
- ☐ Hepatitis
- ☐ Rheumatic fever
- ☐ Epilepsy
- ☐ Latex allergy

Are you allergic to any medications? ______________________

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What serious illnesses have you ever had? ______________________

____

What medicines or tablets are you taking present? ______________________

____

Who is your medical practitioner? ______________________

Have you ever had Botox or Dermal Fillers? ______________________

Women – Are you Pregnant? ______________________

Signed ______________________ Date ______________________

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