SPEARWOOD DENTAL CENTRE

161 Rockingham Road
Hamilton Hill WA 6163

Spearwood Dental Centre

(Mr/Mrs/Ms/Miss) First Name: _____Surname: _____

Address:_____

Suburb: _____ Post Code_____

Phone: Home: _____Mobile:_____Work:_____

Date of Birth: _____/_____/_____ Occupation_____

Private Health Fund:_____ Membership Number _____

Emergency Contact: _____

How did you find us? Referred by friend_____ / Google / Flyer / Facebook

MEDICAL HISTORY

Please tick if you have any of the following conditions:

- ☐ Asthma
- ☐ Blood Disorder
- ☐ Blood thinning medication
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart surgery or complaint
- ☐ Hepatitis
- ☐ High or low blood pressure
- ☐ HIV/AIDS
- ☐ Joint replacement
- ☐ Osteoporosis
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ For females: are you pregnant
- ☐ Do you smoke

Allergy to any medication, food or other substance_____

If you take <u>any</u> prescription or non-prescription medication, please list

_____

_____

Name of family doctor _____ Phone number _____

REASON FOR DENTAL VISIT

- ☐ Dental checkup
- ☐ Scale and polish
- ☐ Broken tooth or filling
- ☐ Decay/hole in tooth
- ☐ Wisdom teeth
- ☐ Dentures
- ☐ Crowns/Veneers/Bridges
- ☐ Toothache
- ☐ Bleeding gums
- ☐ Dental implants
- ☐ Teeth grinding or clenching
- ☐ Other _____

I acknowledge the information given above is accurate. I understand that payment is required at the end of each visit.

SIGNATURE _____ DATE_____