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Wallamurra Medical Centre
191 Abbott Street
Cairns QLD 4870

Welcome to Future Dental

Name: _____

DOB: _____

Home Phone: _____

Work Phone: _____

Mobile: _____

Residential Address: _____

Occupation: _____

Place of employment: _____

Person to contact in the time of an emergency: _____

Husband/ Wife/ Partner/ Mother/ Father/Friend /Other Doctor

Contact email address: _____

Do you have private dental health insurance YES / NO

If Yes, what is the name of your fund? _____

How did you find our phone number / address (please circle)

- | | | | |
|-------------------|-------------|--------------|------------------------|
| Friend | Doctor | Dentist | Television Advertising |
| Our Business Card | White pages | Yellow pages | Radio Advertising |
| PDC Directory | Our Website | Newspaper | |
| A Directory | Other | _____ | |

Whom may we thank for referring you to our practice?

Please list the main reasons for seeking care today: _____

MEDICAL HISTORY

In order to render dental treatment of a high standard, it is necessary to have the following information (which will be handled confidentially). Please help us protect your health and well being...

Please complete your medical history on the next page – Thankyou

MEDICAL HISTORY -

Do you have any allergies e.g. Penicillin, aspirin or disinfectants? YES / NO

If YES please list:

Are you pregnant YES / NO

If YES... How many weeks? ____ Is this your first pregnancy YES / NO

Do you bruise or bleed easily after injury? YES / NO

Have you ever experienced prolonged bleeding? YES / NO

Have you ever had a difficult tooth extraction? YES / NO

Have you taken Aspirin in the last 7 days? YES/ NO

Have you had any of the following medical conditions?

Heart Attack	YES / NO	Heart Trouble	YES / NO
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Blood Pressure	YES / NO	Heart Murmur	YES / NO
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A Stroke	YES / NO	Rheumatic Fever	YES / NO
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Major Operation	YES / NO	Vascular Problems	YES / NO
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Diabetes	YES / NO	Cancer or Tumours	YES / NO
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Kidney disease	YES / NO	Asthma	YES / NO
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Lung Disease	YES / NO	Glaucoma	YES / NO
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Thyroid Disease	YES / NO	Nervous Disorders	YES / NO
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Arthritis	YES / NO	Frequent headaches	YES / NO
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Please give details of all medications being taken currently including over the counter medicines;

Please give details of medical conditions:

Have you ever had any other serious illness? YES / NO

If yes please specify:

Have you been in hospital in the last two years? YES / NO

If YES please give reason: _____

Have you ever had a blood transfusion? YES / NO

Are you under and medical treatment or currently taking any medication?

YES / NO *if yes please list...*

HIV, AIDS and some types of hepatitis are transmissible by blood, saliva and bodily secretions. Do you think you might be in a high risk group? YES / NO

Are there any matters you would like to discuss with the dentist alone?
YES / NO

Signature: _____ Date ____-____-20____

Signature: _____ Date ____-____-20____

Thank you for entrusting your oral health to us. We are proud to offer you the latest technology and techniques and our finest attention.