Dr David R. McInerney B.D.Sc.(W.A.)
Dental Surgeon
3 Station Road
Margaret River WA 6285
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AMR DENTAL

PATIENT MEDICAL HISTORY

To aid us in thoroughly evaluating your present dental condition, please complete this questionnaire. This information will form an important part of your surgery record, and will be held in the strictest confidence.

Surname _____ (Mr / Mrs / Ms / Miss)

First names _____ Date of birth _____

Home Address _____

Postal Address (if different) _____

Phone number: Home _____ Work _____ Mobile _____

Email address _____

Occupation _____ Employer's Name _____

Employers Address _____

Medical Doctor's name _____

Do you have any private ancillary health insurance? Yes/No Name of fund _____

Contact person (in case of emergencies) _____ Phone number _____

MEDICAL HISTORY

Are you receiving any medical treatment at the moment? If so, what for? _____

_____

Do you have any allergies to penicillin any other drugs/medicines, latex or any other allergies? If so please specify

_____

Have you ever had excessive bleeding requiring special treatment? _____

Do you bleed or bruise easily? _____

Do you take any prescription or non prescription drugs regularly? Which ones _____

_____

When was your last visit to the dentist? _____

Females – are you pregnant? Yes/No

Have you ever had any of the following:

a) Heart trouble (including heart murmur or artificial valves)	Yes/No	h) Epilepsy	Yes/No
		i) Osteoporosis	Yes/No
b) Cortisone therapy	Yes/No	j) Anaemia	Yes/No
c) Diabetes or high blood sugar	Yes/No	k) Jaundice	Yes/No
d) Family history of diabetes	Yes/No	l) Chemotherapy/radiation treatment	Yes/No
e) Rheumatic Fever	Yes/No	m) Any artificial joint replacements e.g. hip/knee	Yes/No
f) Hepatitis B or C	Yes/No	n) High blood pressure	Yes/No
g) HIV or Aids	Yes/No	o) Low blood pressure	Yes/No

Any other medical conditions not mentioned above _____

Are you a smoker? Yes/No If so for how many years _____

Do you suffer from bleeding gums? Yes/No Bad breath? Yes/No

If you have anything you wish to discuss with the dentist in private please tick _____

We require payment for service on the day of treatment.

Please indicate your prefered payment method to settle your account today:

Cash ☐ EFTPOS ☐ Credit Card ☐ Cheque ☐ Other ☐

As a courtesy to this surgery, 24 hours notice is required if you are unable to attend your scheduled appointment.

We reserve the right to add additional administrative fees if terms of trading are exceeded.

All information is treated with complete professional confidentiality.

I the undersigned, agree to abide by these requests.

Signature: _____ Date: _____