

Welcome to Dendy Village Dental

Thank you for supplying us with the following information. We treat it with a high level of confidentiality.

Title:.....

Surname:..... First Name:..... Middle Name:.....

Date of Birth:.....

Address:.....

Telephone Numbers: Home:..... Mobile:..... Work:.....

Occupation:.....

Company Name:.....

Business Address:.....

Email:.....

Do you have Dental Extra's cover with an insurance company?.....

Approximate date of last dental visit:.....

Who/what recommended you to us?.....

MEDICAL HISTORY

Your medical history will be reviewed routinely in accordance with the Dental Practice Board of Victoria Guidelines. The boxes below are for this purpose and will be filled out in the future.

Do you have a history of the following? Circle where applicable.

RHEUMATIC FEVER	DIABETES	HEPATITIS	HIGH BLOOD PRESSURE
EXCESSIVE BLEEDING	ALLERGIC REACTION TO DRUGS	ARTIFICIAL HIP/KNEE	
EPILEPSY	ASTHMA	PENICILLIN ALLERGY	HEART AILMENTS
			PACE MAKER

Have you suffered a serious illness?

Details:.....

Are you presently receiving medical attention?

Details:.....

Are you taking any medicines or tablets?

Details:.....

Name and contact details of the GP you attend:.....

For women, are you pregnant?..... Due date:.....

Client's signature:..... Date:.....

Dentist signature:..... Date:.....

I have reviewed and updated my medical history as at the date noted below:

Once all update boxes are used, please have new form completed by client.

DATE: CLIENT SIGNATURE DENTIST SIGNATURE
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