DR STEPHEN POHAN

Please take time to answer all questions as thoroughly as you can. This will assist us in providing the best possible treatment for you. All information will be treated with professional confidentiality (Our Privacy Policy and Charter of Patient Rights can be found on our website).

PERSONAL DETAILS

Title: Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname:

First Name: Preferred Name:

Date of Birth:

Home Address:

Suburb: Postcode:

Postal Address: Postcode:

Home Phone: Mobile: Work:

Email:

Emergency Contact: Relationship: Phone:

APPOINTMENT REMINDERS OR CHANGES

Please consent to which method you prefer us to contact you on:

SMS Message ☐ EMAIL Reminder ☐

PRIVATE INSURANCE, MEDICARE & DVA DETAILS

Private Health Insurance: _____

Medicare Number: Patient Reference: (number next to name) Exp:

Other:

OTHER

Person responsible for fees:

Reason for attending?

Are you nervous/anxious dental treatment?

Do you consent to us taking x-rays and understand the associated risks (click here)? YES ☐ NO ☐

Do you consent to us taking photographic and/or audio visual records? YES ☐ NO ☐

MEDICAL QUESTIONNAIRE - PRIVATE AND CONFIDENTIAL

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Medical Conditions:
Please indicate if you have EVER had any of the following: (Please Tick)

Heart Conditions/treatment	Y ☐	N ☐	Details
Rheumatic fever/heart valve surgery	Y ☐	N ☐	Details
High or low blood pressure	Y ☐	N ☐	Details
Asthma/Bronchitis/other lung condition	Y ☐	N ☐	Details
Gastric ulcer/ GI conditions	Y ☐	N ☐	Details
Blood or bleeding disorder	Y ☐	N ☐	Details
Joint replacement/Arthritis/other joint condition	Y ☐	N ☐	Details
Osteoporosis/low bone density	Y ☐	N ☐	Details
Thyroid Conditions	Y ☐	N ☐	Details
Liver/ Kidney conditions	Y ☐	N ☐	Details
Diabetes	Y ☐	N ☐	Details
Epilepsy	Y ☐	N ☐	Details
Nervous System disorders	Y ☐	N ☐	Details
Neurological conditions e.g. depression, anxiety	Y ☐	N ☐	Details
HIV/AIDS or Hepatitis or Tuberculosis	Y ☐	N ☐	Details
Radiation Therapy/Chemotherapy	Y ☐	N ☐	Details
Treatment for any form of cancer	Y ☐	N ☐	Details
Organ or Bone Marrow transplant	Y ☐	N ☐	Details
Are you Pregnant?	Y ☐	N ☐	Details

Other conditions not listed

Do you smoke? Y ☐ N ☐ Social ☐ If so, how many per day? Previously If so, how long ago?

Do you have regular alcohol? (please tick) Daily ☐ Weekly ☐ Social ☐ Never ☐

Current Medications (prescription, over the counter, herbal OR regular injections):

Allergies: Y ☐ N ☐ If so, details:

Do you or have you taken any of the following medications? (Please Tick)

Fosamax ☐	Zometa ☐	Warfarin ☐	Eliquis ☐
Actonel ☐	Boniva ☐	Pradaxa ☐	
Prolia ☐	Aredia ☐	Xarelto ☐	

Your Medical Practitioner:

Patient's Signature: _____ **Date:**

Submit Form **Do Not sign at this stage. Just click to submit this form.**