

CONFIDENTIAL EVP DENTAL MEDICAL HISTORY
Patient Information Update

Welcome to EVP Dental, please answer all of the following questions as accurately as possible to assist us in our effort to provide you with the best dental treatment.

All information will be treated with complete professional confidentiality.

Dr. Mr. Mrs. Ms. Miss. Mstr.

Surname _____ First Name _____

Have your contact details changed? Yes No

(If you answered yes, then complete the following)

Address: _____

_____ Postcode _____

Telephone: Home _____ Work _____ Mobile _____

Email : _____

Occupation _____

Work Address: _____

Who is responsible for payment of your account? _____

Address _____ Home Phone _____

_____ Work Phone _____

Do you have private health cover? Yes No

If so which fund? _____

Please turn over for the medical questionnaire

PRIVATE AND CONFIDENTIAL MEDICAL QUESTIONNAIRE

To ensure our medical records are correct please answer the following

I have medical information that I do Not wish to write down but would prefer to discuss with the dentist in private. Yes No

Are you currently receiving medical treatment? Yes No

Name of your doctor: _____

Address: _____ Telephone: _____

Please list any medications you are currently taking (including oral contraceptives and/or naturopathic remedies).

Are you allergic to penicillin? Yes No

Please list any other known allergies? _____

Females only: Are you pregnant or think you might be? Yes No

Have you a history of any of the following? (Please circle)

Diabetes	Yes	No	Rheumatic fever	Yes	No
Asthma	Yes	No	Lung disease	Yes	No
Hepatitis	Yes	No	Bleeding abnormalities	Yes	No
Arthritis	Yes	No	Multiple sclerosis	Yes	No
Epilepsy	Yes	No	Heart condition	Yes	No
High blood pressure	Yes	No	Kidney/liver disease	Yes	No
Low blood pressure	Yes	No	Joint replacement?	Yes	No
Radiation Therapy	Yes	No	Transplanted organ	Yes	No
			Or bone marrow	Yes	No

Do you smoke? Yes No *if Yes, how many per day?* _____

Is there any other information that you feel may be of value regarding your dental treatment?
Please add it below

Patient's Signature _____ Date _____