cosmic Smile dental

Suite 212, 40 Yeo St
Neutral Bay NSW 2089
(02) 9904 2880
www.cosmicsmile.com.au

Please note that all information on this medical/dental form will remain strictly confidential.

Surname_____ Title_____

Given Names_____ Date of Birth _____

Home number_____ Work Number_____

Mobile number_____

Email_____ Fax _____

Home address_____

Preferred method of contact ☐ Phone ☐ Email ☐ SMS

Occupation_____

If the patient is a minor please note below the name of the parent or guardian completing this form

Surname_____ Title_____

Given Names_____

Name of your Doctor: _____ Phone number: _____

Female patients: Are you pregnant? _____ How many Months? _____

Have you had any serious illnesses? _____

If yes please indicate: _____

Are you currently taking any medications or tablets regularly? Eg. Aspirin, Bisphosphonate

If yes please indicate: _____

Do you have any allergies to Penicillin or other drugs? _____

Is your blood pressure normal, high or low? _____

Do you smoke? _____ How many per day? _____

In case of an emergency please contact:

Name: _____ Phone number: _____

Have you ever had any of the following? Please tick those that apply to you:

☐ Heart Disease	☐ Osteoporosis	☐ Epilepsy
☐ Rheumatic fever	☐ Tumours or cancers	☐ Stroke
☐ Pacemaker	☐ Radiation Therapy	☐ Blood disease
☐ Heart Murmur	☐ Chemotherapy	☐ Anaemia
☐ Artificial joints	☐ Thyroid disorder	☐ Excessive bleeding
☐ High/Low BP	☐ Sinus problems	☐ Liver disease
☐ Endocarditis	☐ Respiratory problems	☐ Fainting / Dizziness
☐ HIV/AIDS	☐ Asthma	☐ Kidney disease
☐ Hepatitis: Type_____	☐ Diabetes	☐ Other - specify_____
☐ Tuberculosis	☐ Psychological problems	