# Dr Stephen Pohan & Associates
## Welcome to Our Dental Practice

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 (please ask us for our Privacy Policy or our Charter of Patient Rights).

**PERSONAL DETAILS**

Title: Dr/Mr/Mrs/Miss/Ms/Other _____

Surname: _____

First Name: _____ Preferred Name: _____

Date of Birth: _____

Home Address: _____

_____ Postcode: _____

Postal Address: _____ Postcode: _____

Home: _____ Mobile: _____ Work: _____

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

**INSURANCE DETAILS**

Private Health Insurance: _____ Member No: _____ Patient ID: _____

Medicare Number: _____ Patient Reference: _____

Veteran Affairs Number: _____

**OTHER**

Person responsible for fees: _____

How did you hear about us? _____

Reason for attending? _____

_____

Are you nervous/anxious dental treatment? _____

Do you consent to us taking x-rays and or photographic records? _____

## 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 Circle)**

| | | | |
|---|---|---|---|
| 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 |
| 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

Do you have regular alcohol (please circle) Daily Weekly Social Never

**Current Medications (prescription, over the counter, herbal OR injection**):

**Allergies:** Y N If so, details:

**Do you or have you taken any of the following medications? (please circle)**

| | | |
|---|---|---|
| Fosamax | Boniva | Xarelto |
| Actonel | Aredia | Eliquis |
| Prolia | Warfarin | |
| Zometa | Pradaxa | |

Medical Practitioner:

**As a courtesy we try to confirm your appointment the day before via: (please circle)**

Home Phone Mobile Phone SMS

Patient's Signature: Date: