CHARLESTOWN DENTAL
WALLSEND DENTAL

Charlestown Dental
18 Frederick St,
Charlestown
(02) 49 43 6884

Wallsend Dental
59 Nelson St,
Wallsend
(02) 49 51 7733

Large Off Street Parking at Charlestown

Medical History Form

Title: Dr / Mr / Mrs / Miss / Ms

Surname: _____

First Name: _____ Date of birth: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: (H) _____ (W) _____ (M) _____

Occupation: _____

Employer's name: _____

Health fund for Dental cover: _____ Membership No: _____

Medical Practitioner: _____ Suburb: _____

Past/Current medical conditions:
Information about your medical history is for your dentists use only. All dental treatment provided at Charlestown Dental Surgery is performed by independent dentists. Please keep Newcastle Dental up to date with any changes in your medical history.

	No	Yes		No	Yes
Anaemia			Hepatitis A, B or C		
Arthritis			High Blood Pressure		
Artificial Joints			Irregular Heart Beat		
Asthma			Kidney Disorder		
Bleeding Disorder			Liver Disorder		
Blood Transfusion			Lung Disorder		
Cancer			Lupus		
Chemotherapy			Osteoporosis/Bone Disorders		
Cholesterol			Radiotherapy		
Diabetes			Reactions to Anaesthetics		
Endocarditis			Rheumatic Fever		
Epilepsy			Smoker		
Gastro Intestinal Disorder			Stomach Ulcer		
Heart Attack/Angina			Stroke		
Heart Bypass			Tuberculosis		
Heart Murmur			Vascular Disorder		
Heart Valve Problem			Are you pregnant?		
Others			>Specify:		

Current Medication for all Medical Conditions

Allergies to Penicillin or other drugs

Infectious History

Any Recent Hospitalisation / Surgery

Other relevant details

I agree that the above is a true and accurate record. I understand that Newcastle Dental requires payment on the day of treatment. Any expenses, costs or disbursements incurred by Newcastle Dental in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

Signature: _____date_____