

MORTON DENTAL

Noosa Professional Centre
Lanyana Way
Noosa Junction 4567
Ph; 07 54553577

MEDICAL-DENTAL HISTORY

PATIENT Last Name _____
First Names _____ (Dr. Mr. Mst. Mrs. Ms. Miss)

ADDRESS Street _____
Suburb _____ Postcode _____
Phone (Home) _____ (Work) _____ (Mob) _____

POSTAL ADDRESS
(If different from above) _____

DATE OF BIRTH _____

ARE YOU IN A FUND FOR DENTAL _____ **WHICH ONE** _____

WHERE DID YOU HEAR ABOUT US?

**The diseases / conditions listed below could affect treatment, have you had any of the following?
Please circle YES or NO.**

Asthma..... Yes / No	Blood Disease..... Yes/No
Rheumatic Fever Yes / No	Adverse Drug Reaction..... Yes/no
Diabetes..... Yes / No	Radiation Therapy..... Yes/No
Heart Ailment..... Yes / No	Cortisone Therapy Yes/No
Hepatitis A/B/C..... Yes/ No	Adverse Reaction to Local Anaesthetic Yes/No
Blood Pressure H/L Yes /No	Excessive Bleeding after Extractions..... Yes/No
Kidney Disease..... Yes/ No	Allergic to any medication Yes/No
Do you Smoke Yes/ No	Do you or ever taken Biphosphonates (eg Fosomax) ... Yes /No
Epilepsy Yes/ No	Medications currently being taken :.....
Lung Disease Yes / No	_____

**If you require antibiotic cover, please advise if you are taking contraceptive medication.
If you require an X-Ray, please advise us if you are pregnant Y / N**

Signed _____ **DATED** _____