Please complete and bring to Your First Appointment. Thank You

NORTHERN BEACHES ENDO

ENDODONTISTS

Dr. Sydney Bader
BDS (Wits) C Endo (Temple)

Dr. James Wealleans
DMD (Florida) C Endo (Texas)
American Board Certified

Suite 2, 23 Howard Avenue
Dee Why NSW 2099
T: 02 9981 1461

Date: _____

Dr/Mr/Mrs/Ms/Miss
Patient's Name
(please print) _____

Address _____

Suburb _____

State _____ Postcode _____

Sex ❑ Male ❑ Female

Date of Birth _____ Age _____

Phone H _____ W _____

Mobile _____ Email _____

Patient's Occupation _____

Are you in a health fund? ❑ Yes ❑ No

Do you hold a Veterans Affairs Gold Card? ❑ Yes ❑ No

Referred by Dr. _____

Are you under the care of any other dental specialist? ❑ Yes ❑ No

Have you ever been treated here before? ❑ Yes ❑ No

If so, when? _____

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1. General Health

❑ Excellent ❑ Good ❑ Fair ❑ Poor

2. Are you under the care of a doctor for any medical conditions?

❑ Yes ❑ No

If yes, please explain _____

3. Name and address of family doctor

4. Are you wearing a pacemaker or heart valve prosthesis or do you have a joint replacement or any other medical implant?

❑ Yes ❑ No

If yes, please explain _____

5. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?

❑ Yes ❑ No

If yes, please explain _____

6. Are you taking any kind of medication (prescribed or non-prescribed) or drug at this time?

❑ Yes ❑ No

If yes, please explain _____

7. Have you been diagnosed as having HIV, AIDS (Acquired Immune Deficiency) or ARC (Aids Related Complex)?

❑ Yes ❑ No

8. Are you pregnant?

❑ Yes ❑ Months ❑ No ❑ N/A

9. Have you ever undergone endodontic/root canal treatment?

❑ Yes ❑ No

Circle any of the following to which you are allergic or have had an unusual reaction to.

Penicillin	Aspirin	Nitrous Oxide	Sulpha Drugs
Codeine	Steroids	Erythromycin	Valium
Sedatives	Ibuprofen	Latex/Rubber	Flagyl

Other _____

10. Do you have a history of any of the following disorders?

Lung Disease	Blood Disorders	Anaemia	Stomach Ulcer/Reflux
Sinus Trouble	Thyroid Trouble	Asthma	Fainting Spells
Heart Trouble	Herpes	Heart Attack	Chronic Bronchitis/Cough
Hay Fever	Arthritis	Heart Murmur	Shortness of Breath
Kidney Trouble	Convulsions	Diabetes	Rheumatic Fever
Tuberculosis	Epilepsy	Glaucoma	Cancer Treatment
Hepatitis A	Angina	Depression	Psychiatric Treatment
Hepatitis B	Stroke	Migraine	High Blood Pressure
Hepatitis C	Sleep Apnoea	Palpitations	Hives or Skin Rash

11. Are you taking or have you ever taken any medication for Osteoporosis (Bisphosphonate Drugs)?

❑ Yes ❑ No

If yes, please explain _____

12. Do you smoke? (cigs, vaping, marijuana, etc)

❑ Yes ❑ No *How many per day?* _____

13. Do you drink alcohol?

❑ Yes ❑ No *How much per week?* _____

14. Do you have a My Health Record? ❑ Yes ❑ No

15. Is there anything else about your health we should know?

I agree the above information is to the best of my knowledge true and correct

Signature _____ Date _____