Name……

PARKSIDE DENTAL CLINIC

160 UNLEY ROAD
UNLEY S.A. 5061
PHONE (08) 8271 7506
FAX (08) 8271 0076
EMAIL reception@parksidedental.com.au
ABN 11 510 466 324

DR. RICHARD SALTER
DR. ROSS NAPOLI
DR. PHIL ALLEN
DR. DUSAN MARKOVIC
DR. NERITA SIDHU

PRACTISING IN ASSOCIATION

Are you presently having any treatment or taking any medication?
(Please list any medications below)

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Do you have (or have you ever had) any of the following?

Heart Disease	YES	NO
High Blood Pressure	YES	NO
Hepatitis	YES	NO
AIDS/ HIV	YES	NO
Epilepsy	YES	NO
Diabetes	YES	NO
Rheumatic Fever	YES	NO
Asthma	YES	NO
Tuberculosis	YES	NO
Bleeding problems	YES	NO
Allergies	YES	NO
Other Medical Conditions	YES	NO

If yes……
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Are you allergic to any of the following?

Penicillin	YES	NO
Local Anaesthetic	YES	NO
Ladies, are you pregnant	YES	NO

Please sign here……

Date……