New dental patient form

Your details

TITLE:

FIRST NAME:

SURNAME:

DATE OF BIRTH:

OCCUPATION:

ADDRESS:

POSTCODE:

MOBILE:

HOME:

WORK:

EMAIL ADDRESS (TO RECEIVE OUR NEWSLETTER):

NAME OF FAMILY DOCTOR (GP):

DOCTOR'S PHONE NUMBER:

EMERGENCY CONTACT NAME:

PHONE NUMBER:

RELATIONSHIP:

MEDICARE NUMBER:

PATIENT REFERENCE NUMBER ON THE CARD:

NAME OF PRIVATE HEALTH FUND:

MEMBERSHIP NUMBER:

SAMPLE

How did you hear about us? ☐ GP ☐ Friends ☐ Advertisement ☐ Newspaper ☐ Other

How would you like to be contacted? ☐ SMS ☐ Call on mobile ☐ Home phone

Have you ever had any of the following medical conditions? PLEASE TICK EITHER YES OR NO IN ALL BOXES.

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
Blood pressure	☐ YES	☐ NO	Asthma	☐ YES	☐ NO	Osteoporosis medicine	☐ YES	☐ NO
Heart disorder	☐ YES	☐ NO	Bronchitis	☐ YES	☐ NO	Cancer	☐ YES	☐ NO
Pacemaker	☐ YES	☐ NO	Breathing problem	☐ YES	☐ NO	Radiotherapy	☐ YES	☐ NO
Chest pain	☐ YES	☐ NO	Smoking	☐ YES	☐ NO	Chemotherapy	☐ YES	☐ NO
Cardiac surgery	☐ YES	☐ NO	AIDS or HIV	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO
Bleeding disorder	☐ YES	☐ NO	Hepatitis (A,B,C)	☐ YES	☐ NO	Blood transfusions	☐ YES	☐ NO
Rheumatic fever	☐ YES	☐ NO	Stroke	☐ YES	☐ NO	Organ transplant	☐ YES	☐ NO
Depression	☐ YES	☐ NO	Stomach ulcer	☐ YES	☐ NO	Other (please specify)	☐ YES	☐ NO
Sinusitis	☐ YES	☐ NO	Thyroid problem	☐ YES	☐ NO			
Snoring	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO			
Diabetes	☐ YES	☐ NO	Bone problem	☐ YES	☐ NO			

Do you have allergies? ☐ Yes ☐ No Please specify:

Are you pregnant? ☐ Yes ☐ No Please let your dentist know to prevent X-ray exposure to your baby.

MEDICATIONS TAKEN (PLEASE LIST ALL)

SPECIAL NEEDS

What is the purpose of your visit today? ☐ Check-up ☐ Toothache ☐ Bleeding gum ☐ Broken tooth ☐ Other

- I hereby give consent to my dentist to take X-rays and photos of my teeth as part of my check-up and dental record.
- I am aware of $100 fee of late cancellation and failing to attend Clinic policy and I understand 24 hours (for week days) and 48 hours (for weekends) notice is necessary to cancel my appointment in the courtesy of clinics and other patients right.
- I hereby accept all the responsibility for the account and I agree if my health fund does not cover my dental treatment for any reason, I will pay all the costs and fees involved and will claim through my health fund myself.

SIGNATURE:

DATE: