New Patient Forms

CONFIDENTIAL INFORMATION

Dr ❑ Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Master ❑

Surname: .... First Name: .... Date of Birth: / /

Address: ....

Suburb: .... Postcode: ....

Home Phone: .... Business Phone: ……………................

Mobile: ....

E-mail Address: ....

Occupation: .... When was your last dental visit? ....

Who to contact in case of emergency: .... Contact No: ....

Who referred you to our practice? ....

If you have Private Dental Insurance, which fund are you a member of? ....

CONFIDENTIAL MEDICAL HISTORY

Are you currently being treated for or have you ever been treated for any of the following:

❑ Asthma
❑ Rheumatic Fever
❑ Diabetes
❑ Hepatitis
❑ Kidney Disease
❑ Artificial Joints/ Valves
❑ Thyroid disorders
❑ Epilepsy
❑ Malaria
❑ Angina
❑ Blood disorders
❑ Pacemaker
❑ Nervous Disorders
❑ Heart Ailments
❑ A Stroke
❑ Blood Pressure Low/High
❑ Organ Transplants
❑ Other

If you have ticked other, please list:

....

....

Are you currently taking any medications? YES / NO

If you answered yes, please list: ....

Do you have any drug or dietary allergies? YES / NO

Please list: ....

Have you ever had an unfavourable reaction to local anaesthetic? YES / NO

Ladies, is there any possibility you may be pregnant? YES / NO

Name of Medical Practitioner .... Phone No: ....

Signature: .... **Date:** / /

We request and expect payment at the time of treatment. For your convenience we accept cash, cheques, eftpos, and all major credit cards.