The Dental Surgery, Newstead

Patient Information Form

Title & Name _____

Preferred Name _____ Gender: M/F

Residential Address _____

_____ Postcode _____

Postal Address (if different) _____

Contact phone numbers Home ( ) _____ Mobile _____

Occupation _____ Work Phone ( ) _____

Date Of Birth _____ Email address _____

Emergency contact – Name _____ Number _____

Family Doctor / GP's Name _____

Private health insurance? **Y/N** Name of Health fund _____

Please list **ALL** current medications, pills, tablets, injections or puffers _____

_____

_____

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

Heart conditions (inc murmur)	Y/N	Epilepsy	Y/N
Bleeding or blood disorder	Y/N	Kidney disease	Y/N
High or low Blood pressure	Y/N	Rheumatic fever	Y/N
Asthma or respiratory problems	Y/N	HIV / AIDS	Y/N
Stroke	Y/N	Steroid therapy	Y/N
Diabetes	Y/N	Thyroid or adrenal gland disease	Y/N
Cancer	Y/N	Nervous / psychological condition	Y/N
Radiation therapy	Y/N	Stomach or digestive condition	Y/N
Liver Disease or hepatitis	Y/N	Any other condition	Y/N
Hip, Knee or joint replacement	Y/N	Currently pregnant?	Y/N

Please detail from above: _____

_____

_____

Please be aware that we are unable to provide treatment to patients who have active cold sore lesions. If you have an active or developing cold sore and your appointment is in the near future, please contact reception to reschedule your appointment.

Do you have any known allergies to medications, drugs, foods or latex? **Y/N**

Please detail: _____

_____

_____

Please turn over...

Are you taking or have you ever taken any medications **for bone cancer, bone disease or osteoporosis?**

e.g. Fosamax, Actonel, Zometa, Pamisol, Aredia, Aclasta, Bonefos **Y/N**

Please detail: _____

_____

Are you, or have you ever been a smoker? **Y/N** How many per day? _____ Years _____

If you have quit smoking, how many years since you smoked? _____

If there is any other aspect of your medical or dental history that you would like to discuss in a confidential environment please indicate **Y/N**

Privacy policy

A Copy of our privacy policy is available for you to read at reception and is also on our website.

Account Information & Policy

Accounts are to be paid in full on the day of treatment. We can claim the rebate from your private health fund directly through Hicaps.

Person responsible for account (if under 18) _____

For all cancellations, 24 hours must be given. Failure to do so will incur a fee. Accounts referred for collection will incur legal costs and commission added to the amount due.

Recalls

As part of a commitment to your oral health we conduct recalls periodically as tailored to your needs. What is your preferred method of contact for recalls?

Email / SMS / Post / Phonecall

For new patients: How did you hear about us or who referred you to our surgery?

_____

By signing below I agree with the privacy, account & cancellation policies.

Signature _____ Date _____

Office Use Only

Checked by practitioner: _____ Date: _____