PATIENT INFORMATION FORM

Full Name: ______________________ Date of Birth: ____________

Preferred Name: ______________________ Pronouns: ____________

Residential Address ______________________

______________________ Postcode ____________

Postal Address (if different) ______________________

Home (   ) ____________ Mobile ____________ Work Phone (   ) ____________

Occupation ____________ Email address ____________

Emergency contact – Name: ____________ Phone: ____________

GPs Name or Practice ______________________

Are you of Aboriginal and/or Torres Strait Islander origin? **Y/N** Biological Gender: ____________

Please list **ALL** current medications, pills, tablets, injections or puffers here: ______________________

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If you cannot recall all of your medications we are happy to request a medications list from your GP.

If this is the case please let our reception team know when returning this document.

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

Condition		Condition		Condition	
Heart conditions (inc murmur)	Y/N	Cancer	Y/N	HIV / AIDS	Y/N
Heart surgery	Y/N	Chemotherapy	Y/N	Autoimmune condition	Y/N
Rheumatic fever	Y/N	Radiation therapy	Y/N	Osteoporisis/Osteopenia	Y/N
Bleeding or blood disorder	Y/N	Hepatitis or Liver Disease	Y/N	Steroid therapy	Y/N
High Blood pressure	Y/N	Stroke or TIA	Y/N	Thyroid or adrenal gland disease	Y/N
Low Blood pressure	Y/N	Epilepsy	Y/N	Stomach or digestive condition	Y/N
Asthma	Y/N	Hip, Knee or joint replacement	Y/N	Currently Pregnant?	Y/N
Respiratory condition	Y/N	Mental health condition	Y/N	Currently Breastfeeding?	Y/N
Diabetes	Y/N	Kidney disease	Y/N		

Please detail from above: ______________________

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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.

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

Please detail: ______________________

So we can best care for you, please indicate any disability/impairments: ______________________

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: ______________________

Have you ever smoked or vaped? **Y/N** If yes, How many per day? ________ Years ________
If you have quit, when did you cease (approx.)? ________
Please list substances smoked here: ________

How often do you drink alcohol? (please circle) **Daily / Weekly / Monthly / Rarely / Never**
When you do drink, how many standard drinks would you usually consume? ________

Are you, or have you ever taken recreational drugs? **Y/N** If yes, please list here: ________

Is there anything else that you would like to discuss in a confidential environment? **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, Confirmation and Non-Attendance Policy

Do you have private health insurance? **Y/N** Name of insurer: ________

Person responsible for account (if under 18) ________

- Accounts are to be paid in full on the day of treatment. Accounts referred for collection will incur legal costs and commission added to the amount due.
- We will contact you three (3) business days prior to your appointment to confirm your attendance. If we are unable to contact you directly, we will attempt to contact any linked family members (within our practice management software) or your emergency contact. Unconfirmed appointments may be cancelled.
- Failure to attend a scheduled appointment, or cancellations without 24 hours notice will incur a fee.

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? **Please tick** O **Email** O **SMS** O **Phone call**

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

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By signing below I agree with both the Privacy Policy, and the Account, Confirmation & Non-Attendance Policy.

Signature ________ Date ________

Office Use Only
Checked by practitioner: ________ Date: ________