New Patient - Medical & Dental History

Patient Details: Title:_______

Surname:____________________________ Given name:__________________________ DOB: ________________

Address: ____

Suburb:____ State:_____________ Postcode:_______________

Mobile:__________________________________ Home Phone:_________________________________

Email:____

Emergency Contact:_____________________ Phone:______________________ Relationship: ________________

Are you completing this form on behalf of somebody else? ☐ No ☐Yes (Please fill in the details below)

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other: ____

Surname: ___________________ Given Name: _____________________ Phone: ____________________________

Private Health Fund ☐ No ☐ Yes (Please fill in details) Fund name: _____________________________________
Card number: ________________________ Member reference No. _____________

Medical History - Your medical history is important to us as it may influence our treatment approach.

GP Name:________________________ GP Practice:__________________________ GP Phone: ________________

Please be assured that any information provided is confidential and we appreciate your co-operation.

Please ☑ if you have had any of the following.

☐ Abnormal/excessive bleeding
☐ Angina
☐ Artificial heart valve
☐ Asthma
☐ Blood disorder (private details)
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☐ Blood pressure (high/low)
☐ Blood thinner
☐ Bone disease (e.g. Osteoporosis)
- ☐ Current or past
- ☐ Taking medications

☐ Cancer
☐ Cardiac surgery/pacemaker
☐ Congenital heart defect
☐ Diabetes type 1/type 2
☐ Epilepsy
☐ Heart disease
☐ Heart murmur
☐ Hepatitis A/B/C/D
☐ HIV positive
☐ Immune deficiency
☐ Kidney/liver disease

☐ Neurological disorder
☐ Oral ulceration
☐ Prosthetic joints
☐ Psychiatric care
☐ Radiation/chemotherapy
☐ Reflux
☐ Rheumatic fever
☐ Steroid therapy
☐ Stroke
☐ Thyroid disorder
☐ Other: ______________________

Are you a smoker? ☐ No ☐ Yes - how often? ____

Are you pregnant? ☐ No ☐ Yes - how many months? ____

Are you taking medication (including natural supplements)? ☐ No ☐ Yes (Please fill in the details below)

____

Allergies

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs ☐ Types of metals ☐ Other: __________________

What is the reason for your attendance today? ____

When was your last dental examination? ____

When were your last dental x-rays taken? ____

How did you hear about us? ☐ Our website ☐ Facebook ☐ Google/Internet ☐ Yellow pages ☐ Word of mouth
☐ Other: ____________________________

Patient/Legal guardian signature:_____________________________________ Date:_________________________