Welcome To Our Practice

Welcome to our practice. We look forward to giving you the best service possible so that you can enjoy the benefits of optimal dental health.

Patient Details

Title: Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other ______________________________________

Surname: ____ Given Name: ______________________________________

Date of Birth: _________/_________/_________ Preferred Name: ___________________________________

Residential Address: ____

Suburb: ____P/Code ___________ State: __________________________

Contact: (Home): _____________________________________ Mobile: ____

Contact (Work): ______________________________________ Email: ____

Emergency Contact: Name ____________________________ PH: ______________________ Relation: _______________

Occupation: ____ Company: ____

Health Fund: ____ Name of GP: ______________________________________

Please select method of communication:

Telephone ☐ Email ☐ Letter ☐

☐ **Yes! I would like to opt in to receive a newsletter and be among the first to receive special offers from my dental practice.**

Medical History *Please indicate below:*

- ☐ Abnormal Bleeding
- ☐ Angina
- ☐ Artificial Heart Valves/Valve Defect
- ☐ Asthma
- ☐ Blood Pressure High ☐ Low ☐
- ☐ Bisposphonates – Bone Disease
- ☐ Cardiac Surgery/Pacemaker
- ☐ Congenital Heart Defect
- ☐ Diabetes Type 1☐ Type 2 ☐
- ☐ Epilepsy
- ☐ Infectious Diseases:________________
- ☐ Joint Replacement: ________________
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis A☐ B☐ C☐ D☐
- ☐ HIV Positive
- ☐ Nervous Disorders
- ☐ Oral Cancer
- ☐ Pregnant? Due Date: ________
- ☐ Rheumatic Heart Disease
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Warfarin or Aspirin Medication
- ☐ Other Serious Illness

Are you taking Medication? If yes, please list below:

____

DENTAL ALLERGIES *Please Circle*

Penicillin **Y / N** Aspirin **Y / N** Iodine **Y / N** Sulpha Drugs **Y / N** Latex **Y / N**

Other: ____

How will you be paying your account?

CASH ☐ C/CARD ☐ EFTPOS☐ HICAPS ☐ CHQ ☐

Patient's Signature: ____ **Date:** ___________________________

Parental Guardian Signature (if patient under 18 years) ____