

PATIENT INFORMATION FORM



Patient Title: Mr Mrs Ms Miss Dr

SURNAME..... FIRST NAMES.....

DOB..... WORK PLACE / PHONE.....

RESIDENTIAL ADDRESS.....

SUBURB POST CODE.....

POSTAL ADDRESS (If different from above).....

PHONE..... MOBILE..... WORK.....

EMAIL.....

I am financially responsible for my own account (please tick)

If you are not financially responsible please complete section below

RESPONSIBLE PARTY:

RELATIONSHIP TO PATIENT..... Financially responsible (please tick)

Mr Mrs. Miss Ms Dr

NAME..... **MOBILE**.....

ADDRESS..... **EMAIL**.....

*** Please discuss account options with reception staff where more than one person is responsible for accounts.**

NAMES OF ANY CHILDREN/RELATIVE PREVIOUSLY TREATED BY THIS PRACTICE

1..... 2.....

WHO SUGGESTED YOU ATTEND THIS PRACTICE?.....

WHO IS YOUR: (1) DENTAL PRACTITIONER.....

(2) MEDICAL PRACTITIONER.....

EMERGENCY CONTACT NAME:.....**MOBILE**..... **PHONE**.....

MEDICAL HISTORY.

Are you at present receiving any medical attention? Yes No

Are you taking any medicine or tablets? Yes No

If yes, please list medication:.....

HAVE YOU HAD ANY OF THE FOLLOWING? Please Tick if the answer is 'YES'

- | | | |
|--|---|---|
| Diabetes <input type="checkbox"/> | Arthritis <input type="checkbox"/> | Bleeding Disorders <input type="checkbox"/> |
| Heart problems <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Asthma <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Allergic reactions <input type="checkbox"/> (if yes please specify below) |
| High Blood Pressure <input type="checkbox"/> | Hepatitis & Other Viral Diseases <input type="checkbox"/> | |

Other.....

Have you ever had any other serious illness? YES NO If the answer is 'YES' please list names

Female patients, do you believe you are or may be pregnant? YES NO

Have you ever had any problems with Dental treatment? YES NO

On future visits if there are any changes to the above information please advise staff as applicable.

SIGNATURE..... **DATE**.....

NAME.....