

PATIENT DETAILS

Full Name:..... Preferred Name:

Address: Postcode:

Telephone: Home: Mobile:

Email:

Date of Birth: Sex: Male Female

If patient is under 18, please complete the following

Parent / Guardian 1

Name:..... Relationship:.....

Address: AS ABOVE or Postcode:

Telephone: Mobile: Home:

Email:

Parent / Guardian 2

Name:..... Relationship:.....

Address: AS ABOVE or Postcode:

Telephone: Mobile: Home:

Email:

Who is responsible for the account: Parent/Guardian 1 Parent/Guardian 2 Self Other:.....

Name of Health Fund: NOT APPLICABLE or

We use the following methods of contact (unless you advise us otherwise):

Appointment Reminders: via SMS Preferred Mobile:.....

Recall Reminders: via Email Preferred Email:.....

Receipts and Statements: via Email Preferred Email:.....

MEDICAL HISTORY

Dentist's Name:.....

Medical Practitioner's Name:

Are you under regular care with your medical practitioner? Yes No

If yes, please provide reasons:

Have you taken any regular medication in the past year? Yes No

If yes, please provide details:

Is there any reason for you to suspect that you are at risk of having any blood borne viral disease? Yes No

Have you ever suffered from any of the following:

Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment for cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Haemophilia or prolonged bleeding after injury or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear, nose or throat surgery (ie. adenoids, tonsils, grommets)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other illness or disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy to any food or drug?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(Females) Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature:..... Date:

(Parent / Guardian if applicable)