SOUTH MELBOURNE
DENTAL GROUP

NEW PATIENT FORM

PATIENT DETAILS

SURNAME:		TITLE: (e.g Mr/Mrs/other)	
FIRST NAME:		DATE OF BIRTH:	
HOME ADDRESS: P/CODE:		BUSINESS ADDRESS: P/CODE:	
PH:	MOBILE:	(BH) PH:	FAX:
EMAIL:			
NAME OF PERSON RESPONSIBLE FOR FEES:		Relationship:	
EMERGENCY CONTACT: ADDRESS: PH:		Relationship:	
MEDICAL DOCTOR: ADDRESS:			
DO YOU HAVE **PRIVATE HEALTH INSURANCE**? YES □ NO □		IF YES, WHICH HEALTH FUND?	
WHO RECOMMENDED THIS PRACTICE TO YOU?			

MEDICAL DETAILS

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE TICK:					
	YES	NO		YES	NO
HIGH BLOOD PRESSURE			KIDNEY DISEASE		
HEART AILMENT			THYROID PROBLEMS		
RHEUMATIC FEVER			EXCESSIVE BLEEDING OR BLOOD DISORDER		
ASTHMA, CHEST OR BREATHING PROBLEMS			BONE DISORDERS (e.g. osteoperosis, on Fosamax?)		
TUBERCULOSIS			HEPATITIS		
DIABETES			AIDS/HIV		
STOMACH OR BOWEL PROBLEMS (eg ulcer)			EPILEPSY		
DO YOU SMOKE? YES □ NO □ How many?_____/day			FEMALE PATIENTS, ARE YOU PREGNANT?		
LIST ANY PREVIOUS ILLNESSES:					
HAVE YOU EVER HAD ANY PROBLEMS WITH DENTAL TREATMENT? (e.g. Adrenaline intolerance)					
DO YOU HAVE: AN ARTIFICIAL HIP, HEART VALVE OR PROSTHETIC IMPLANT?					
DO YOU HAVE ANY ALLERGIES? (If yes, please list e.g. Penicillin, Latex):					
ARE YOU PRESENTLY UNDER MEDICAL CARE?					
ARE YOU TAKING ANY DRUGS, MEDICINES OR TABLETS? (If yes, please list)					

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check up reminders. I understand that payment of accounts in full is required on the day and accept full liability for Healthcare fund claims which are rejected. In the event where an overdue account is referred to a collection agency or solicitors, I will be liable for all legal costs and commission arising.

Signed: _____ Date: _____

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