

## PATIENT INFORMATION FORM

TITLE: DR/MR/MRS/MS/MISS/MAST/OTHER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME: \_\_\_\_\_  
(SURNAME) (FIRST NAME/S - IN FULL)

RESIDENTIAL ADDRESS: \_\_\_\_\_

SUBURB: \_\_\_\_\_ CITY: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

POSTAL ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
(If different from above)

MOBILE NO: \_\_\_\_\_

EMAIL: \_\_\_\_\_

BUSINESS NAME & ADDRESS: \_\_\_\_\_

\_\_\_\_\_ PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

NAME/ADDRESS OF NEXT OF KIN: \_\_\_\_\_

RELATIONSHIP (eg. husband/wife/partner/mother/father) \_\_\_\_\_ PHONE: \_\_\_\_\_

PERSON RESPONSIBLE FOR FEES - SELF/PARENT/GUARDIAN: \_\_\_\_\_

DO YOU HAVE HEALTH INSURANCE? IF SO, INSURANCE COMPANY: \_\_\_\_\_

WHERE APPLICABLE, POLICY NAME AND MEMBER / POLICY NUMBER: \_\_\_\_\_

IF A THIRD PARTY SUCH AS MEDICAL INSURANCE OR ACC IS INVOLVED IN THE REIMBURSEMENT FOR YOUR TREATMENT, WE REMIND YOU TO CONFIRM THE SITUATION WITH THEM BEFORE TREATMENT COMMENCES.

WHO REFERRED YOU? \_\_\_\_\_

DENTIST'S NAME/ADDRESS: \_\_\_\_\_

FAMILY DOCTOR'S NAME/ADDRESS: \_\_\_\_\_

**HAVE YOU HAD ANY OF THE FOLLOWING?** (Please circle if the answer is YES)

RHEUMATIC FEVER

DIABETES

HEART AILMENTS

EPILEPSY

KIDNEY DISEASE

HIGH BLOOD PRESSURE

ASTHMA

HEPATITIS

EXCESSIVE BLEEDING

ARE YOU A SMOKER?

YES / NO

ARE YOU LIKELY TO BE AT RISK FOR AIDS OR HEPATITIS B?

YES / NO

HAVE YOU EVER SUFFERED ANY SERIOUS ILLNESS?

YES / NO

PLEASE LIST ANY MEDICAL CONDITIONS: \_\_\_\_\_

HAVE YOU HAD ANY PREVIOUS OPERATIONS?

YES / NO

ARE YOU AT PRESENT: 1) RECEIVING MEDICAL ATTENTION?

YES / NO

2) TAKING MEDICINES OR TABLETS?

YES / NO

IF YES TO 2), PLEASE LIST NAMES OF DRUGS: \_\_\_\_\_

DETAIL ANY ALLERGIES: \_\_\_\_\_

FEMALE PATIENTS - ARE YOU PREGNANT OR BREAST FEEDING?

YES / NO

PREFERRED SURGEON (Please circle): No Preference / Dr Neil Luyk / Dr Ian Cathro

I give you permission to exchange information with my dentist, doctor and other medical or dental professionals. I understand that this information will be confidential. I agree to be contacted regarding aspects of my care.

PATIENT'S SIGNATURE: \_\_\_\_\_

(PARENT/GUARDIAN TO SIGN FOR PATIENT IF HE/SHE IS UNDER 16 YEARS OF AGE) DATE: \_\_\_\_\_