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: _____ **NHI NO:** _____

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: _____

<u>HAVE YOU HAD ANY OF THE FOLLOWING</u>? (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**

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:** _____