CONFIDENTIAL **Y Magit and H Marget T/A East Bentleigh Dental Group**

Patient Information Form

Patient Surname: ..... Mr / Mrs / Ms / Miss / Master / Dr **(Please circle)**

Patient Given Name: ..... Date of Birth: .....

Address: .....

..... Postcode: .....

Telephone: (Home): ..... Tel: (Work): ..... (Mobile): .....

Email: ..... Occupation: .....

Please tick if agree to receive emails from EBDG ☐ Heath Fund for Dental Benefits : .....

Emergency Contact: ..... Telephone: .....

Medical Practitioner: ..... Telephone: .....

How did you find out about our practice? **(Please circle)**

Internet / Radio / Local Paper / Yellow Pages / Family / Friends / Health Fund / Other .....

Person responsible for payment of account:

Full Name: ..... Relationship to patient: .....

Address: .....

..... Postcode: .....

Telephone (Home): ..... (Work): ..... (Mobile): .....

PATIENT MEDICAL HISTORY

Are you or have you ever been treated for the following **(please tick)**

☐ Rheumatic Fever	☐ Asthma	☐ Heart Ailments	☐ Stroke
☐ Diabetes	☐ Epilepsy	☐ Nervous Disorders	☐ Kidney Diseases
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ Depression
☐ Malaria	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Blood Disorders
☐ Angina	☐ Creutzfeldt Jacob	☐ Snoring at night	☐ Headaches
☐ Jaw Pain	☐ Dental Phobia	☐ Grinding/Clenching of teeth	

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

If not, reasons why? .....

Do you have any artificial body parts including heart valves joints etc? ☐ Yes ☐ No

Do you have any drug allergies? ☐ Yes ☐ No

If yes, please name them: .....

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list: .....

Have you ever had an unfavourable reaction to local or general anaesthetics? Yes No

Are you pregnant? ☐ Yes ☐ No

I certify that the above information is true and correct. In accordance with the Privacy Act (1988) I authorise any person or company to give information as may be required in response to credit inquiries. I have read and understand the TERMS AND CONDITIONS OF TRADE (overleaf) which form part of, and are intended to be read in conjunction with this Patient Information Form and agree to be bound by these conditions.

Signed ..... Date .....

Full Name .....