

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 or SMS 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: Gold or Kiis / 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)**

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Ailments | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Kidney Diseases |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Creutzfeldt Jacob | <input type="checkbox"/> Snoring at night | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Dental Phobia | <input type="checkbox"/> 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. **If unable to keep appointment 24 hours notice should be given or a fee may apply**

Signed Date

Full Name