



Contact Details

Surname:.....First Name:.....
Preferred Name:.....Title:..... Date of Birth:___/___/___
Home Address:.....Post Code:.....
Home Phone:.....Mobile:.....
Email:.....Occupation:.....
Emergency Contact Name:.....Relationship:.....Phone:.....

◆ Do you have private health insurance that covers dental? No Yes > Name of fund:.....

How did you hear about us? Live/Work locally Internet Local Paper

Patient referral > whom may we thank for the referral?

Medical History (or leave blank if you would prefer to discuss directly with your dentist).

Do you have any allergies? Latex Penicillin Other:

Do you have (or have a history of) the following:

- High/Low Blood Pressure
- Autism
- Heart Condition
- Asthma
- Cancer
- Chemo/Radiotherapy
- Osteoporosis
- Joint Replacement
- Arthritis
- Kidney/Liver Problems
- Stroke
- Diabetes
- Epilepsy
- HIV/AIDS
- Hepatitis
- Anxiety/Depression
- Dementia
- Other

If you ticked yes to any of the above conditions, please specify any relevant details here:

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◆ Do you take injections or tablets for **Osteopenia or Osteoporosis?** (i.e. Prolia injections, Actonel) Yes No

◆ Do you take blood thinners? Yes No

Do you take any other medications? If yes, please list here.....

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◆ Do you smoke or vape? Yes In the past Not at all

If Yes, How many in a day?

◆ How should we contact you for 6-monthly check-up reminders?

- SMS Email Letter No reminders please!

◆ Is there anything else we should know?.....

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Please be assured all the information you have provided will be handled with strict confidentiality in accordance with the Privacy Amendment Act 2004 and the Health Records and Information Act 2002.

By signing this form, you hereby agree and acknowledge that: (i) you have provided accurate information to the best of your knowledge; (ii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iii) payment is due at time of service unless other arrangements have been made.

Patient/Guardian's Signature: _____ Date: ___/___/___