PATIENT RECORD

Please print clearly. We strictly value patient confidentiality

Preferred Title: MR/MRS/MISS/MS/DR/PRO/MSTR (Surname) (First Name/s)			
ADDRESS: POSTCODE:			
TELEPHONE (Home) (Mobile) (Work) EMAIL:			
DATE OF BIRTH: OCCUPATION:			
HOW DID YOU HEAR ABOUT OUR PRACTICE?			
NAME OF DR / GP MEDICAL CENTRE / CONTACT PH			
Have you ever had any of the following? (Please tick Yes or No)	Cardiovascular	Heart murmur	☐ Yes No ☐
		Rheumatic fever	☐ Yes No ☐
		Open heart surgery	☐ Yes No ☐
		High blood pressure	☐ Yes No ☐
		Stroke	☐ Yes No ☐
	Respiratory	Asthma	☐ Yes No ☐
		Chest & lung disease	☐ Yes No ☐
		Sinus / Hayfever	☐ Yes No ☐
	Other	Epilepsy	☐ Yes No ☐
		Diabetes	☐ Yes No ☐
		Kidney problems	☐ Yes No ☐
		Gastric problems	☐ Yes No ☐
		Depressive illness	☐ Yes No ☐
		Radiotherapy	☐ Yes No ☐
		Artificial joint or prosthetic	☐ Yes No ☐
Are you taking any medications? If yes please list			
Do you have any known allergies? Please list.			
Have you ever experienced excessive bleeding or bruising?			
Women : Are you currently pregnant? If so how many weeks?			
Have you ever had contact with :	HIV virus	☐ Yes No ☐	
	Hepatitis B	☐ Yes No ☐	
	Hepatitis C	☐ Yes No ☐	

If you are unsure of any questions on this form please feel free to ask the receptionist or your dentist before treatment is started.

Full payment is required at each appointment

Failure to pay after treatment shall make you liable for any Collection Agency costs to recover payment from you.

VISA, MASTERCARD, Q CARD AND EFTPOS AVAILABLE.

I confirm that the information written above is true and correct to the best of my knowledge.

Patient/Parent/Guardian Signed : _____ Date : _____