Patient Form

Title	☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr ☐Master
First Name	
Last Name	
Preferred Name	
Date of Birth	/ /
Gender	☐Male ☐Female

Home Phone	( )
Mobile Phone	
Work Phone	

Street Address			
Suburb			
Postcode		State	

Email	

Occupation	
Company	

Emergency Contact	
Emergency Phone	

Health Fund

Health Fund			
Membership No.			
Expiry Date	/ /20	No. on Card	

Preferred Method of Contact

Method of Contact	☐Telephone ☐SMS ☐Email ☐SMS

Medicare

Medicare Number	
Number on Card	
DVA Number	

Medical Doctor Information

Doctor's Name			
Provider Number			
Telephone			
Street Address			
Suburb			
Postcode		State	

Medical History *(if you answer YES, please provide the details)*

Have you ever been hospitalised?	☐No ☐Yes	
Are you taking any medications	☐No ☐Yes	
Are you under care of doctor?	☐No ☐Yes	
Do you smoke?	☐No ☐Yes	
Have you had a joint replacement surgery?	☐No ☐Yes	

For females

Are you pregnant?	☐No ☐Yes	
Are you on contraceptive medicine?	☐No ☐Yes	

Have you suffered one of the following?

Epilepsy	☐No ☐Yes	Diabetes	☐No ☐Yes
Rheumatic Fever	☐No ☐Yes	Asthma	☐No ☐Yes
High/Low Blood Pressure	☐No ☐Yes	Haemophilia / Prolonged Bleeding	☐No ☐Yes
Heart Conditions	☐No ☐Yes	HIV/AIDS	☐No ☐Yes
Blood Disease	☐No ☐Yes	Hepatitis	☐No ☐Yes

AB cover

Do you need AB cover?	☐No ☐Yes

Have you got any other important health issues?	☐No ☐Yes	

General Allergies

Hayfever	☐No ☐Yes	
Food Allergies	☐No ☐Yes	
Animal Allergies	☐No ☐Yes	
Insect Stings	☐No ☐Yes	

Allergies to Dental Materials

Latex	☐No ☐Yes	Amalgam	☐No ☐Yes
Nickel	☐No ☐Yes	Chromium	☐No ☐Yes

Allergies to Drugs

Penicillins	☐No ☐Yes	Meprobamate	☐No ☐Yes
Codeine	☐No ☐Yes	Thiazide Diuretics	☐No ☐Yes
Iodines	☐No ☐Yes	Insulin	☐No ☐Yes
Salicylates	☐No ☐Yes	Opiates	☐No ☐Yes
Heparin	☐No ☐Yes	Sulfonamides	☐No ☐Yes
Barbiturates	☐No ☐Yes	Procaine/Novocaine	☐No ☐Yes
Tetracaine	☐No ☐Yes	Propoxicane	☐No ☐Yes
Benzocaine	☐No ☐Yes	Procainamide	☐No ☐Yes

Are you allergic to other unlisted drugs?	☐No ☐Yes	

Signature		Date	/ /20