

# New patient

## Medical and dental history



Date:

### Patient details

Title: Mr Mrs Ms Dr Other:

Surname: Given name: D.O.B:

Residential address:

Suburb: State: Postcode:

Postal address (if different):

Home phone: Work phone: Mobile:

Email:

We will send you email communications from time to time, including our regular newsletter and offers.  
Please tick this box if you don't wish to receive communication from us.

Occupation: Company:

Emergency contact: Phone: Relation:

Private health insurer: Member #: Patient #:

Medicare #: Ref #: Expiry: Vets Affairs #: Expiry:

GP name: GP phone:

GP address:

### Preferred method of communication

Email Letter SMS Telephone

### Medical history

**Please tick if you have ever had any of the following:**

Abnormal/excessive bleeding	Cardiac surgery/pacemaker	Oral ulceration
Angina	Congenital heart defect	Prosthetic joints
Artificial heart valve	Diabetes type 1/type 2	Psychiatric care
Asthma	Epilepsy	Radiation/chemotherapy
Blood disorder (name below)	Hearing impairment	Reflux
	Heart disease	Rheumatic fever
Blood pressure (high/low)	Heart murmur	Steroid therapy
Blood thinner	Hepatitis A/B/C/D	Stroke
Bone disease (e.g. Osteoporosis)	HIV positive	Thyroid disorder
Current or past	Immune deficiency	Other condition(s) (name below)
Bisphosphonate therapy	Kidney/liver disease	
Cancer	Neurological disorder	

