NEW PATIENT MEDICAL HISTORY FORM

DENTAL ON ERRARD GROUP

Mr / Mrs / Ms / Mast / Miss/ Dr / Other: _____

Person paying the account? Self / Other

First Name: _____

Name: _____ Phone Number: _____

Surname: _____

Preferred Language: _____

Date of Birth: _____

Are you of Aboriginal or Torres Strait Islander decent? Yes / No

Contact Number: _____

Current Private Health Insurance for Dental? Yes / No

Email: _____

Name of Health fund: _____

Postal Address: _____

Current Ambulance Insurance? Yes / No

Suburb: _____ Postcode: _____

Veteran Affairs Card Number: _____

Emergency contact Name: _____

Is this a Workcover or Work-related injury? Yes / No

Relationship to Emergency Contact: _____

Are you on Blood Thinners? Yes / No

Emergency Contact Phone Number: _____

(Only if under 18 years of age) –

G.P name: _____

Medicare Number: _____ Ref number: _____

G.P Phone Number: _____

Are you eligible for the Child Dental Benefits Schedule (CDBS)? Yes / No

Have you ever had or are you currently experiencing any of the following? Please tick if yes:

□ Angina	□ Anaemia	□ Other Chest Conditions	□ Digestive Condition
□ Heart Disorder/Complaint	□ Excessive Bleeding	□ Allergy to Latex	□ Epilepsy
□ Heart Surgery	□ Hepatitis A, B, C	□ Allergy to Penicillin	□ Fainting Disorder
□ High Blood Pressure	□ H. I. V	□ Artificial Joint/s	□ Kidney Disease
□ Low Blood Pressure	□ Other Blood Condition	□ Bone/Joint Disease	□ Liver Disease
□ Pacemaker	□ Asthma	□ Back/Neck Pain	□ Psychiatric Condition (Eg. Anxiety)
□ Rheumatic Fever	□ Chest Surgery	□ Cancer: _____	□ Sleep Apnoea
□ Stroke	□ Cystic Fibrosis	□ Radiation/Chemo Therapy	□ Thyroid Disease
□ Thrombosis	□ Lung Disease	□ Dementia	□ Do you drink Alcohol Regularly?
□ Other Heart Conditions	□ Pneumonia	□ Diabetes (Type 1 / Type 2)	□ Smoker? How many daily? _____

□ None of the above

Do you have any other allergies/sensitivities? _____

Please list the medications you are taking below. If you have a longer list, please inform our staff

Name of medication	Dose (eg. 10mg)	Reason for taking

How Often do You Brush? _____ How Often Do You Floss? _____ Have You ever had a Sleep Study? _____

How did you hear about us? (If referred by a patient, please include their name, we will send them a voucher!)

- ☐ TV ad
- ☐ Social media
- ☐ Google search
- ☐ Website
- ☐ Yellow pages
- ☐ Health fund
- ☐ Signage
- ☐ Service Station signage
- ☐ Another dentist/practice
- ☐ Staff
- ☐ Word of mouth
- ☐ Patient referral – who? _____
- ☐ Other :_____

I have filled the above form correctly to the best of my knowledge. I have read and signed the *'consent for services document'.*

Patient/ parent/ guardian signature: _____ Date: _____