HOBSONS BAY DENTAL

NEW PATIENT INFORMATION FORM

CONFIDENTIAL

CONTACT DETAILS

TITLE : DR ☐ MR ☐ MRS ☐ MS ☐ MISS ☐ MST ☐ SURNAME : . . . . . .

GIVEN NAME(S) : . . . . . PREFERRED NAME : . . . . . .

DATE OF BIRTH : . . . / . . / . . . . .

HOME ADDRESS : . . . . . .

SUBURB: . . . . . POSTCODE : . . . . . .

MAILING ADDRESS (IF DIFFERENT TO ABOVE) : . . . . . .

HOME PHONE : . . . . . WORK PHONE : . . . . . .

MOBILE PHONE : . . . . . EMAIL : . . . . . .

EMERGENCY CONTACT NAME : . . . . . PHONE: . . . . . .

DOCTOR'S NAME : . . . . . PHONE: . . . . . .

HOW DID YOU FIND OUT ABOUT OUR CLINIC? INTERNET/WEBSITE ☐ WALK/DRIVE BY ☐ ADVERTISEMENT ☐

FRIEND/FAMILY ☐ NAME: . . . . . OTHER ☐ HOW: . . . . . .

DENTAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING CONCERNS?

DISCOLOURED TEETH ☐	SENSITIVITY ☐	MISSING TEETH ☐	PAIN IN JAW ☐
WORN/BROKEN TEETH ☐	FREQUENT HEADACHES ☐	DENTURE ISSUES ☐	GUM PROBLEMS ☐
SNORING ☐	CROOKED TEETH ☐		

HOW LONG AGO WAS YOUR LAST DENTAL VISIT? : . . . . . .

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

HIGH BLOOD PRESSURE ☐	HEART VALVE SURGERY ☐	EXCESSIVE BLEEDING ☐	HEPATITIS ☐
RHEUMATIC FEVER ☐	AIDS/HIV ☐	DIABETES ☐	EPILEPSY ☐
GASTRIC REFLUX ☐	CANCER TREATMENT ☐	JOINT REPLACEMENT ☐	KIDNEY DISEASE ☐
DISABILITY ☐	SLEEP APNEA ☐	BISPHOSPHONATE TREATMENT ☐	

ANY OTHER SERIOUS HEALTH ISSUES OR OPERATIONS : . . . . . .

CURRENT MEDICATIONS : . . . . . .

ANY KNOWN ALLERGIES : . . . . . .

DO YOU SMOKE? : YES ☐ NO ☐ LADIES, ARE YOU PREGNANT : YES ☐ NO ☐

ACCOUNT DETAILS

PERSON RESPONSIBLE FOR FEES: MYSELF ☐ OTHER ☐ NAME : . . . . . .

MEDICARE CARD NO: . . . . . LINE NO: . . . . EXPIRY DATE (MM/YYYY): . . . / . . . .

ARE YOU COVERED BY DENTAL INSURANCE : YES ☐ NO ☐ IF YES, FUND NAME : . . . . . .

CARD NO: . . . . . SERIES NO : . . . .

I UNDERSTAND THAT PAYMENT IS REQUIRED ON DAY OF TREATMENT UNLESS OTHERWISE ARRANGED.
I UNDERSTAND THAT MORE THAN 24HRS IS REQUIRED FOR RESCHEDULING OF APPOINTMENTS.
IN THE EVENT WHERE I HAVE AN OVERDUE ACCOUNT WHICH IS REFERRED TO A COLLECTION AGENCY AND/OR LAW FIRM, I UNDERSTAND I WILL BE LIABLE FOR ALL COSTS WHICH WOULD BE INCURRED AS IF THE DEBT IS COLELCTED IN FULL, INCLUDING LEGAL DEMAND COSTS.

PATIENT/GUARDIAN SIGNATURE : . . . . . DATE : . . . / . . . . / . . . .