NEW PATIENT INFORMATION FORM

To help us serve you to a high standard, please complete the following information. This information is important to us and will be handled confidentially.

1. PERSONAL INFORMATION

Title: Mr/Mrs/Ms/Dr/Mast/Miss **Surname:**

Given Name/s: **Preferred Name:**

Date of Birth: **Email Address:**

Address:

Home Phone: **Work Phone:**

Mobile Phone: **Occupation:**

Who may we thank for referring you?

Alternative/Emergency Contact:

2. BILLING INFORMATION

Do you have Private Health Insurance? Yes / No

Name of Fund: **DVA?** Yes / No

Membership Number: **Number:**

3. MEDICAL INFORMATION

Doctor's (GP) Name: **GP's Number:**

GP's Address:

Regular Dentist Name: **Dentist's Number:**

Dentist's Address:

Do you suffer from or have previously suffered from the following illnesses?

Heart Problems	Yes / No	Kidney Disease	Yes / No
High Blood Pressure	Yes / No	Liver Disease	Yes / No
Blood Disorder	Yes / No	Excessive Bleeding	Yes / No
Tuberculosis	Yes / No	Headaches/Migraines	Yes / No
Diabetes	Type 1 / 2 / No	Chemotherapy	Yes / No
Asthma	Yes / No	Cholesterol	Yes / No
Epilepsy	Yes / No	Nervous/Anxious	Yes / No
Hepatitis	A / B / C / No	HIV/AIDS	Yes / No
Arthritis	Yes / No	Pregnancy	Yes / No

Other Illnesses (not listed above):

Previous Operations:

Allergies:

Medications taken:

I confirm that the above details are true and correct. I will notify the clinician of any changes to my medical history. If necessary, I give permission for my medical practitioner to be contacted for relevant medical advice. I consent to all relevant treatment that will be undertaken, following informed consultation and I will assume responsibility for fees associated with these procedures and agree to pay all costs at each appointment. I also give permission for the use of any photos taken for lecturing, publishing or educational purposes.

I declare that I have read, understood and agree to the terms and conditions of this form and agree to be bound by them. All details on this form are the property of SK Dental and will not be handed to any other party apart from the agency to recover any outstanding monies if necessary.

Patient's (Parent/Guardian) Signature: _____ **Date:** _____