PATIENT INFORMATION FORM

SURNAME.. FIRST NAMES..

DOB.. SCHOOL ATTENDING...

ADDRESS..

SUBURB .... POST CODE………………………………..

PHONE.. MOBILE...

PERSON RESPONSIBLE FOR FEES (Mr/Mrs/Ms/Miss)...

EMAIL ADDRESS...

IF MINOR (UNDER 18 YEARS)

Mother/guardian particulars **Father**

NAME.. NAME...

ADDRESS... ADDRESS...

MOBILE.. MOBILE..

EMERGENCY CONTACT...

MOBILE.. PHONE..

NAMES OF ANY CHILDREN/RELATIVE PREVIOUSLY TREATED BY THIS PRACTICE

1.. 2...

WHO SUGGESTED YOU ATTEND THIS PRACTICE?..

WHO IS YOUR: (1) DENTAL PRACTITIONER..

(2) MEDICAL PRACTITIONER...

MEDICAL HISTORY.

Are you at present receiving any medical attention? Yes/No
Are you taking any medicine or tablets? Yes/No
If yes, please list medication:.. ....

HAVE YOU HAD ANY OF THE FOLLOWING?

Please CIRCLE if the answer is 'YES'

Allergic reactions	Diabetes	Heart problems	Rheumatic Fever
Arthritis	Epilepsy	Kidney Disease	Hepatitis & Other Viral Diseases
Bleeding Disorders	Asthma	High Blood Pressure.	

Have you ever had any other serious illness? YES/NO
If the answer is 'YES' please list names.. ....
Female patients, do you believe you are or may be pregnant? YES/NO
Have you ever had any problems with Dental treatment? YES/NO

On future visits any changes to the above should be advised

PATIENT'S SIGNATURE .... **DATE** ....
Parent/guardian if minor (under 18 years)