New Patient Details

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NAME: **D.O.B:**

ADDRESS: **STATE:** **P/CODE:**

CONTACT NO.'S: **Mobile:** **Home:** **Work:**

EMAIL: **GENDER:**

HEALTH FUND: **GP'S NAME AND PRACTICE:**

EMG CONTACT NAME: **EMG CONTACT NO'S:**

IF YOU ARE UNDER 18 YEARS, ARE YOU COVERED BY THE CHILD DENTAL BENEFIT SCHEDULE: YES: ☐ NO: ☑

MEDICAL HISTORY

MEDICATIONS:

Please List:

HEART

- ☐ Rheumatic fever
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Thrombosis
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Angina
- ☐ Other Heart Conditions:

CHEST

- ☐ Bronchitis
- ☐ Chest Surgery
- ☐ Cystic Fibrosis
- ☐ Emphysema
- ☐ Smoker
- ☐ Pleurisy
- ☐ Pneunomia
- ☐ Other Chest Conditions:

BLOOD

- ☐ Bleeding
- ☐ H.I.V
- ☐ Haemophilia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Anaemia
- ☐ Sickle Cell
- ☐ Other Blood Conditions:

OTHER

- ☐ Diabetes
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Cancer
- ☐ Hiatus Hernia
- ☐ Serious illness
- ☐ Other Conditions:

ALLERGIES

- ☐ Penicillin
- ☐ Aspirin
- ☐ Hay Fever
- ☐ Asthmatic
- ☐ Latex Allergy
- ☐ Other:

WARNINGS

- ☐ No Local Anaesthetic
- ☐ Antibiotic Cover
- ☐ Do Not Recline
- ☐ Pregnant
- ☐ Artificial Joints
- ☐ Warning Card
- ☐ Special Precautions:

PATIENT SIGN: **DATE:** / /