SANDY BAY DENTAL NEW PATIENT INFORMATION

Welcome to Sandy Bay Dental Centre, in order to provide you with complete quality care we need to know about your state of health and medical history. In accordance with the Privacy Amendment Act 2000, and Health Records and Information Privacy Act 2002, all information provided will be treated in strictest confidence and available only to third parties you have consented to. You can view the policy online at https://www.bupadental.com.au/privacy-policy.html.
By signing this form you hereby agree and acknowledge that: (i) you accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentist; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service. *Thank You*

PATIENT INFORMATION:

Title: (please circle) Miss /Mrs /Ms / Mr /Master /Dr. /Other…………..

Surname: ……………………………………………… First name: …………………………………………… Date of Birth: ………/…………/…………

Postal Address: ……………………………………………………………………………………………… Post code: ……………………………………
Phone Home …………………………….. **Work ……………………………..** **Mobile …………………………………………..**
Email Address: ………..
Occupation: ………………………………….. Employer's Name: ……………………………………………………..

EMERGENCY CONTACT

Name: ………………………………………….. Relationship to Patient: ……………………………… Contact Number: …………………………..

PRIVATE HEALTH INSURANCE: Yes or No

If yes, Please specify which health fund: …………………………………… Membership No: ……………………………Series No……………
Veterans Card Holder: Yes or No DVA No.: …………………. Pensioner Card Holder Yes or No Card No.: ……………………………

Child Dental Benefits Scheme: Yes or No Medicare Number: ……………………… Series No: …………

MEDICAL HISTORY: GP: …………………………………………………… Practice: …………………………………………………………………

Allergies	Yes / No	If yes , please note ……
		Do you carry an EPIPEN or equivalent? Yes / No
Artificial Heart Valve	Yes / No	
Abnormal/excessive bleeding	Yes / No	(eg Blood thinners, please list below)
Angina	Yes / No	
Asthma	Yes / No	Do you carry an Inhaler? Yes / No
Blood disorder	Yes / No	………………………………………………………………………………
Blood Pressure	Yes / No	High or Low Medicated: Yes or No (list below)
Bone disease (eg Osteoporosis)	Yes / No	Current or past Bisphosphonate therapy (list below)
Cancer	Yes / No	Radiation/chemotherapy: current or past
Cardiac Surgery	Yes / No	
Congenital heart defect	Yes / No	
Diabetes	Yes / No	Type 1 / type 2
Epilepsy	Yes / No	
Gastro Intestinal Disorder	Yes / No	
Heart disease	Yes / No	
Heart murmur	Yes / No	
Hepatitis	Yes / No	If yes please circle one of the following A B C D
HIV positive	Yes / No	
Immune deficiency	Yes / No	
Kidney / Liver disorder	Yes / No	
Neurological disorder	Yes / No	
Prosthetic joints	Yes / No	
Reflux	Yes / No	
Rheumatic Fever	Yes / No	
Steroid therapy	Yes / No	
Stroke	Yes / No	
Thyroid disorder	Yes / No	
Other condition	Yes / No	………………………………………………………………………………
Females – currently pregnant?	Yes / No	If yes, how many weeks pregnant are you? …………

Current Medications/Supplements: (please note any medications that you are currently taking. It is important that the dentist is made aware of these as they may affect the course of dental treatment that you receive)

………

………

Patient/Legal guardian name: ……………………………… Signature: …………………………… Date: ……………………