HARLEY DENTAL

# New Patient Form

## Patient Details

Title | Given Name(s) | Surname

Preferred Name | DOB / / | Gender ☐ Male ☐ Female ☐ Unspecified

Residential Address

Suburb | State | Postcode | Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Postal Address (if different)

Home Phone | Work Phone | Mobile

Email | Occupation

Doctor/GP (regular) | GP Phone

Emergency Contact | Mobile | Relation

Responsible for Account? ☐ Self ☐ Other | Name | Relation

Residential Address (if different)

Suburb | State | Postcode

## Card Information

Medicare No. | Reference No. | Expiry / /

Dept of Vet Affairs (DVA) No. | ☐ Gold ☐ White | Expiry / /

Gov Concession Card No. | ☐ HCC ☐ PCC | Expiry / /

## Health Insurance Information

Private Health Insurer | Membership No. | Position (e.g. 01)

## Medical History

Have you had or are you suffering from any of the following? Please tick any that apply:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Artificial Joints | ☐ Cold Sores | ☐ Eye Surgery (recent) | ☐ Heart Rate Problems | ☐ Kidney Disease | ☐ Respiratory Problems |
| ☐ Asthma | ☐ Diabetes | ☐ Hepatitis A, B or C | ☐ High Blood Pressure | ☐ Osteoporosis | ☐ Rheumatic Fever |
| ☐ Bleeding Problems | ☐ Dizziness/Fainting | ☐ Heart Attack | ☐ High Cholesterol | ☐ Pace-Maker | ☐ Tuberculosis |
| ☐ Cancer | ☐ Epilepsy | ☐ Heart Murmur | ☐ HIV Positive | ☐ Radiation Therapy | |

Do you have any other disease, condition or problem not listed above? (If yes, please give details) ☐ Yes ☐ No

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## Medical History (Cont'd)

Allergies/reactions? (If yes, please give details) ☐ Yes ☐ No

Are you currently or have you taken any medication or dietary supplements in the last 12 months? (If yes, please give details) ☐ Yes ☐ No

Have you had surgery or been to hospital in the last 12 months? (If yes, please give details) ☐ Yes ☐ No

Have you ever taken medication for osteoporosis? (If yes, please give details) ☐ Yes ☐ No

**Women:** are you pregnant? (If yes, how many months?) ☐ Yes ☐ No **Months**

Have you ever or currently smoked/vaped? (If yes, how many per day?) ☐ Yes ☐ No **Per Day**

## How did you find out about us?

☐ Google Search ☐ Mailout ☐ Referral ☐ Walk In ☐ Other (please specify)

☐ Friend/Family ☐ Newspaper ☐ Social Media ☐ Radio

## Consent

Do you give consent for SMS Reminders? ☐ Yes ☐ No

From time to time we will send you emails. Do you give consent for email notifications? ☐ Yes ☐ No

Do you give consent for photography, x-rays or other clinical records to be for teaching and illustrative purposes? ☐ Yes ☐ No

Do you give consent for photography to be used for promotion/marketing purposes? ☐ Yes ☐ No

## Signature

I understand that information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform Harley Dental of any changes in my medical status. I understand that Harley Dental requires payment on the day of treatment. I understand failure to pay this account in full by the due date may incur additional costs, fees and charges to recover the outstanding amount. I further acknowledge that a charge may apply if I provide insufficient notice (less than 48hrs) or if I fail to attend an appointment without notice.

Signature Date / /