

Patient Details

Title	Given Name(s)	Surname	
Preferred Name	DOB	/	/
Residential Address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspecified	
Suburb	State	Postcode	Aboriginal or Torres Strait Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No
Postal Address (if different)			
Home Phone	Work Phone	Mobile	
Email	Occupation		
Dentist (regular)	Doctor/GP (regular)	GP Phone	
Emergency Contact	Mobile	Relation	
Responsible for Account? <input type="checkbox"/> Self <input type="checkbox"/> Other	Name	Relation	
Residential Address (if different)			
Suburb	State	Postcode	

Card Information

Medicare No.	Reference No.	Expiry	/	/
Dept of Vet Affairs (DVA) No.	<input type="checkbox"/> Gold <input type="checkbox"/> White	Expiry	/	/
Gov Concession Card No.	<input type="checkbox"/> HCC <input type="checkbox"/> PCC	Expiry	/	/

Health Insurance Information

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

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

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

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

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 / /