New Patient Form

CRONULLA DENTAL CENTRE
Over 70 years of Smiles. Trusted by Generations.

PATIENT INFORMATION

First Name: Mr ☐ Miss ☐ Mast ☐ Mrs ☐ Ms ☐ Dr ☐

Preferred Name: Date of Birth:

Surname:

Address:

Suburb: Post Code:

Email:

Contact No:

Occupation:

Reason for Today's visit:

When was your last dental visit?

Are you anxious about seeing the dentist? Yes ☐ No ☐

EMERGENCY CONTACT

Emergency Contact Name:

Emergency Contact Number:

Relationship to Patient:

GENERAL PRACTITIONER INFORMATION

General Medical Practitioner (GP): Doctor's Name:

Practice Name:

Practice Phone Number:

DVA / MEDICARE DETAILS

Medicare Card No: Your No. on Card:

Expiry:

DVA Card: Expiry:

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HEALTH INSURANCE

Private Health Insurance: Yes ☐ No ☐ If YES, which fund? _____

Membership No: _____

Your No. on Card: _____

MEDICAL HISTORY

Please tick any of the following conditions you may currently have.

☐ Asthma	☐ Rheumatic Fever	☐ Hepatitis A/B/C (please circle)
☐ Cancer	☐ Kidney Disease	☐ HIV
☐ Heart Condition	☐ Epilepsy	☐ Bleeding Disorders
☐ Diabetes	☐ Reflux	☐ Anxiety/Depression
☐ Mental Disorders	☐ Prosthetic Replacements	☐ Osteoporosis
☐ Stroke	☐ Thyroid Condition	☐ Musculoskeletal Conditions
☐ Liver Complaints	☐ Arthritis	☐ Pregnant
☐ Low Blood Pressure	☐ High Blood Pressure	☐ Others

Are you taking any medication? (including Vitamins and Supplements), if so, please list:

_____

Please list any allergies you may have:

_____

Are you a smoker? Yes ☐ No ☐

HOW DID YOU HEAR ABOUT US?

Google ☐ Health Engine ☐ Social Media ☐

Referred ☐ Referred person's name: _____

Thank you for providing this important information which will remain part of your confidential record. By signing this document, you believe the above information is true and you agree to be contacted by the practice for your dental related matters.

Sign: _____ Date: _____