Patient Form

Title	☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr ☐Master
First Name	
Last Name	
Preferred Name	
Date of Birth	/ /
Gender	☐Male ☐Female

Home Phone	( )
Mobile Phone	
Work Phone	

Street Address					
Suburb		Postcode		State	

Email	

Occupation	
Company	

Emergency Contact Name		Emergency Contact Phone	

Health Fund

Health Fund			
Membership No.		No. on Card	

Preferred Method of Contact

Method of Contact	☐Telephone ☐Mobile ☐Email ☐SMS

Medicare

Medicare Number		Number on Card	
DVA Number (Veterans only)			

Medical Doctor Information

Doctor's Name					
Telephone					
Surgery Name					
Street Address					
Suburb		Postcode		State	

Medical History *(if you answer YES, please provide the details)*

Have you ever been hospitalised?	☐No ☐Yes	
Are you taking any medications	☐No ☐Yes	
Are you under care of doctor?	☐No ☐Yes	
Do you smoke?	☐No ☐Yes	
Have you had a joint replacement surgery?	☐No ☐Yes	

For females

Are you pregnant?	☐No ☐Yes	
Are you on contraceptive medicine?	☐No ☐Yes	

Have you ever suffered from the following -

Epilepsy	☐No ☐Yes	Diabetes	☐No ☐Yes
Rheumatic Fever	☐No ☐Yes	Asthma	☐No ☐Yes
High/Low Blood Pressure	☐No ☐Yes	Haemophilia / Prolonged Bleeding	☐No ☐Yes
Heart Conditions	☐No ☐Yes	HIV/AIDS	☐No ☐Yes
Blood Disease	☐No ☐Yes	Hepatitis	☐No ☐Yes

Antibiotics Cover

Do you need Antibiotics cover?	☐No ☐Yes

Have you got any other important health issues?	☐No ☐Yes	

Allergies to Drugs

Penicillins	☐No ☐Yes	Meprobamate	☐No ☐Yes
Codeine	☐No ☐Yes	Thiazide Diuretics	☐No ☐Yes
Iodines	☐No ☐Yes	Insulin	☐No ☐Yes
Salicylates	☐No ☐Yes	Opiates	☐No ☐Yes
Heparin	☐No ☐Yes	Sulfonamides	☐No ☐Yes
Barbiturates	☐No ☐Yes	Procaine/Novocaine	☐No ☐Yes
Tetracaine	☐No ☐Yes	Propoxicane	☐No ☐Yes
Benzocaine	☐No ☐Yes	Procainamide	☐No ☐Yes

Are you allergic to other unlisted drugs?	☐No ☐Yes	

General Allergies

Hayfever	☐No ☐Yes		Animal Allergies	☐No ☐Yes
Food Allergies	☐No ☐Yes		Insect Stings	☐No ☐Yes

Allergies to Dental Materials

Latex	☐No ☐Yes	Amalgam	☐No ☐Yes
Nickel	☐No ☐Yes	Chromium	☐No ☐Yes

Question	Scale of 1-10 1 being you dislike strongly and 10 being you are extremely happy
How do you currently rate your smile?	1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
How do you feel about the colour of your teeth?	1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Have you ever suffered from dental pain and if so how did this make you feel?	1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
How nervous are you about having dental treatments?	1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Would you like to change anything about the appearance of your teeth or smile, if so please list:	1. 2.
Have you ever had Botox or fillers?	Yes / No

How did you hear about us?

☐ Signage

☐ Website

☐ Health Engine

☐ Whom can we thank for your referral? _____

☐ Other _____

Signature		Date	/ / 20

By signing you agree that the information entered by you into this form is current and correct to the best of your knowledge.

At Go Dental Surgery we operate under the commonwealth privacy act 1988, any personal information collated from you will be used solely in your best interest at all times to benefit you and will not be disclosed to any 3rd parties

If you have any difficulties completing this form, please inform our staff so that they can assist you. Interpreter services and hearing impaired services can be accessed.