

Preferred title: _____ **Date of Birth:** _____ / _____ / _____
 First Name _____
 Last Name _____
 Preferred Name _____
 Address _____

 Suburb _____ Postcode _____
 Contact Phone Number _____
 Email _____

Patient / Guardian name

(If applicable) _____
 Carer name _____
 (If applicable)
 Contact Phone Number _____

Emergency Contact Name _____
 Contact Phone Number _____

Do you have Private Health Insurance? Yes No
 Hospital Dental
 Fund _____ Ref. Number _____

Medical History

To the best of your knowledge do you have or have you suffered from the following? If possible please provide approximate date of diagnosis.

Heart Rheumatic Fever High Blood Pressure Heart Surgery Pacemaker fitted Heart Murmur Angina Thrombosis
 Other Heart Conditions _____

Chest Bronchitis Emphysema Pneumonia Chest Surgery Smoker Cystic Fibrosis Pleurisy
 Other Chest Conditions _____

Blood Bleeding Hepatitis H.I.V. Anaemia Haemophilia
 Other Blood Conditions _____

Other Diabetes Liver Disease Kidney Disease Epilepsy Cancer Pregnant
 Other Conditions _____

Please state any major surgery you have had in the last five years _____

Allergies and Adverse Reactions

Do you have any allergies? Yes No Do you have any adverse reactions to drugs? Yes No
 If Yes, please state allergy/reaction _____
 Emergency Plan _____

Medicines

There are many medications that may impact upon your oral health or the treatment we plan for you. Please indicate any medications that you are currently taking or have taken recently (including natural therapies). Alternatively a list from your GP can be attached.

_____ _____
 _____ _____

Are you on any blood thinners such as Warfarin or Aspirin? Yes No

Department of Veterans Affairs' Card Number
 (If applicable) _____

Is this consultation related to Workcover or a Work related injury or Transport Accident? Yes No

How did you hear about Mint Dental?

Family? _____ Internet Signage
 Personal Recommendation? _____
 Facebook Instagram Other _____

Please take care to fill out this form completely. We rely on your information to provide you with appropriate services.
 Privacy Policy – We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Would you like to receive appointment reminders, practice communication and information via Email, SMS and Phone? Yes No

Due to ADA requirements we will require this form to be updated every two years.

I agree to be responsible for all payment of fees and understand that payment is due at the time of the service.

Patient/Guardian Signature (if applicable) _____
 Sign _____ Date: ____ / ____ / ____