NEW PATIENT FORM

Please be assured that this form is maintained in
accordance with State and Federal Privacy Legislation

HAPPY ROCK dental

SURNAME: _____ TITLE: _____ GIVEN NAME: _____

PREFERRED NAME: _____ DATE OF BIRTH: _____ GENDER: M ☐ F ☐ OTHER ☐

ADDRESS: _____ SUBURB: _____ POST CODE: _____

HOME PHONE: _____ MOBILE: _____ WORK: _____

EMAIL: _____ PRIVATE HEALTH FUND: _____

☐ PLEASE TICK IF YOU DO NOT WANT TO RECEIVE OUR MONTHLY NEWSLETTER

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

MEDICAL HISTORY

How do you rate your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Who is your general Practitioner: _____ PHONE: _____

Have you had or are you suffering from any of the following? (please tick)

☐ Heart Trouble/ Surgery	☐ Epilepsy	☐ Eating Disorder
☐ Cardiac Pacemaker	☐ Sleep Apnea	☐ Stomach or Digestive condition/reflux
☐ High Blood Pressure	☐ Stroke	☐ Prosthetic Implant / joint replacement
☐ Low Blood Pressure	☐ Osteoporosis	☐ Organ or Bone Marrow Transplant
☐ Diabetes	☐ Nervous Disorders	☐ Steroid Therapy
☐ Hepatitis	☐ Asthma	☐ Other (Please Specify)
☐ Rheumatic Fever	☐ Infectious Conditions	_____
☐ Arthritis	☐ Liver or Kidney Disease	Are you Pregnant? _____
☐ Thyroid Trouble	☐ Excessive or Prolonged Bleeding	Do you Smoke or Vape? _____

Are you Allergic to anything? eg: local anaesthetic, latex, penicillin, peanut, etc. (Please specify)

_____

Are you taking any medications, including natural remedies. (please specify)

_____

I have accurately completed this pre-clinical form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatments.

PATIENT/GUARDIAN SIGNATURE: _____ PRINT NAME: _____ DATE: _____

CHECKED BY: _____ PRINT NAME: _____ DATE: _____