MGA DENTAL

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Master

First Name:

Last Name:

Preferred Name:

Date of Birth:................................/............................./........................ Gender: ☐ Male ☐ Female

Home Phone:.. Mobile Phone:...

Street Address:

Suburb:

State: Postcode:

Email:

Occupation:..

Emergency Contact (Name & Phone):...

Health Fund: ☐ Yes ☐ No Name of Fund:..

Preferred Method of Contact: ☐ Telephone ☐ SMS ☐ Email

Do you have a regular Dentist: ☐ Yes ☐ No

Reason for Visit:..

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

REFERRAL INFORMATION: ☐ Internet ☐ Yellow Pages ☐ Walked Past ☐ Mailbox

☐ Patient Referral (Please provide name so that we can say thanks) ....

PLEASE COMPLETE OTHER SIDE

Have you ever been hospitalised?: ☐ Yes ☐ No Details: ....

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Are you taking any medications?: ☐ Yes ☐ No

Details: ....

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Are you under care of a Doctor?: ☐ Yes ☐ No Details: ....

Do you smoke?: ☐ Yes ☐ No

Are you currently having regular injections (eg Osteoporosis)?: ☐ Yes ☐ No

Details: ....

Are you pregnant?: ☐ Yes ☐ No How many months ....

Are you on contraceptive medicine?: ☐ Yes ☐ No Details: ....

Have you suffered any of the following?

Epilepsy:	☐ Yes	☐ No	Diabetes:	☐ Yes	☐ No
Rheumatic Fever:	☐ Yes	☐ No	Asthma:	☐ Yes	☐ No
High Blood Pressure:	☐ Yes	☐ No	Bleeding Problems:	☐ Yes	☐ No
Heart Conditions:	☐ Yes	☐ No	HIV/AIDS:	☐ Yes	☐ No
Blood Disease:	☐ Yes	☐ No	Hepatitis (A, B or C):	☐ Yes	☐ No

Any other important health issues?: ☐ Yes ☐ No

Details: ....

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Do you have any allergies?: ☐ Yes ☐ No

Details: ....

....

PLEASE SIGN AND DATE

Signature .... Date:.........../.............../20 ....