NEW PATIENT MEDICAL & DENTAL HISTORY FORM
PERSONAL DETAILS

Dr/Mr/Master/Mrs/Ms/Miss		**Surname**		**Given Name**	
Date of Birth	/ /	Occupation		**Email**	
Phone (H)		Home Address			
Phone (M)					
Phone (W)		Contact Preference:	□ Home Phone □ Mobile □ Work □ Email		
Health Insurance	□No □Yes_________	Emergency Contact (Name & Number)			
GP Name		GP Address/Suburb (if known)			
GP Phone					
Referred by:	□ Patient ________	□ Google / Website	□ Walked Past	□ Bethania Child Care	
	□ Others ________	□ Yellow Pages	□ Qld Health	□ Health Professional	

□ I would like to receive special offers and news emails from Bethania Waters Dental	
Are you interested in any of the following services?	□ **Tooth Whitening** □ **Crowns/Bridges** □ **Cosmetic Dentistry** □ **Orthodontic (Invisalign/ClearCorrect)**

MEDICAL HISTORY

Have you ever had any of the following? Please tick & circle if applicable.

□ Steroid Therapy	□ Diabetes	□ Artificial Joint (i.e. Hip, Knee)
□ Asthma / Hay fever	□ Epilepsy	□ Kidney Disorder
□ Emphysema / Respiratory Conditions	□ Stomach Ulcers / Digestive Conditions	□ Bleeding or Other Blood Disorders
□ Tuberculosis	□ Heart Valve Disorder	□ Thyroid Disease
□ Chemo / Radiation Therapy	□ Heart Disease / Heart Murmur	□ Hepatitis / Other Liver Disease
□ Tumors / Cancer	□ Cardiac Pacemaker	□ Contact with HIV / AIDS
□ Rheumatic Fever	□ High / Low Blood Pressure	□ Transplants
□ Sinus Problems	□ Stroke	□ Nervous Conditions

Please provide more information for the above if required.		
Are you pregnant? If yes, how many months?		
Have you had any serious illness in the past two years? If yes, please provide other information.		
Are you allergic to anything? If yes, please list allergies.		
Are you currently taking any medication? If yes, please list >>		
Do you smoke or drink? (Please tick)	□ Smoke	□ Drink
Do you normally require anti biotic cover before dental treatment?		

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I acknowledge that the use of any study models, x-rays, computer images and photographs at dental seminars, lectures and publications may occur upon discussion and consent between dentist and patient first.
- I am aware that payment is required on the day of treatment, and any cancellations with less than 12 hours' notice will incur a $30 cancellation fee.

If under 18, Parent/Guardian Name ____________________________ (Parent must accompany to initial visit)

______________________________ / / ____

Signature Date

☐ Entered
☐ Scanned