Scott Makiol Biodentistry – New Patient Form

TITLE (MR/MRS/MISS/MS/MX/DR): MX SURNAME: _____

GIVEN NAME(S): _____

PREFERRED NAME: _____ DATE OF BIRTH: 01 / JAN / 1999

RESIDENTIAL ADDRESS: _____

STATE: QLD POSTCODE: 4105

POSTAL ADDRESS: _____

STATE: _____ POSTCODE: _____

HOME PH: _____ WORK PH: _____ MOBILE: _____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE? _____

WHO IS YOUR REGULAR GP? NAME: _____ PRACTICE: _____

DO YOU HAVE PRIVATE HEALTH INSURANCE? ☐ **YES** ☐ **NO** INSURER NAME: _____

OCCUPATION: _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR PRACTICE? ☐ **YES** ☐ **NO**

IF YES, WHAT IS THEIR NAME? _____

EMERGENCY CONTACT DETAILS: NAME: _____ RELATION: _____

PHONE: _____ EMAIL: _____

DO YOU REQUIRE ANTIBIOTICS BEFORE UNDERGOING DENTAL TREATMENT? ☐ **YES** ☐ **NO**

DO YOU CURRENTLY HAVE OR HAVE YOU HAD THE FOLLOWING:

	CURRENTLY HAVE	HAD BEFORE	NO
AIDS/HIV	☐	☐	☐
BLOOD DISORDERS	☐	☐	☐
DIABETES	☐	☐	☐
ASTHMA	☐	☐	☐
EPILEPSY	☐	☐	☐
TUMOURS	☐	☐	☐
CANCER	☐	☐	☐
SINUS TROUBLE	☐	☐	☐
PREGNANCY	☐	☐	☐
STROKE	☐	☐	☐
HEART PROBLEMS	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
LOW BLOOD PRESSURE	☐	☐	☐
ARTIFICAL JOINTS	☐	☐	☐
RHEUMATIC FEVER	☐	☐	☐
EXCESSIVE BLEEDING	☐	☐	☐
SMOKING	☐	☐	☐
ALLERGIES	☐	☐	☐

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

CLEAR FORM **SUBMIT FORM**