Mobile DentalCareSA

NEW PATIENT FORM (*Required to be completed)

*Title: ……*Given Names: ……*Surname: ……

*Date of Birth: …… *Gender: Male / Female Preferred Name:…… ……

*Residential Address: ……

*Postal Address: ……

*Phone: Home: …… Work: …… Mobile: ……

Email ……

Would you like SMS reminders for future appointments? ☐ Yes ☐ No Your Occupation? ……

Medicare Number …… Position on Card …… Expiry Date ……

DVA Number (if applicable) ……

Do you have Private Health Insurance? Yes/No (Please Circle) - Name of Fund: ……

Private Health Card Number: …… Position on card (eg. 01):……

How were you referred to Mobile Dental Care SA? (please circle one)

Google Other Patient Dentist Family/Friend Newspaper Other (Please Specify)

If Other, Please specify: ……

*Emergency contact: Name: ……Number: ……

*Name and Address of your regular Doctor……

*Do you have or have you had any of the following conditions? (please tick Yes or No)

High Blood Pressure	☐ Yes ☐ No	Asthma	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	If Yes, Which Type?……	
HIV (AIDS)	☐ Yes ☐ No	Hepatitis A B or C (please specify)	☐ Yes ☐ No		
Rheumatic Fever	☐ Yes ☐ No	Do you suffer from Sleep Apnoea?	☐ Yes ☐ No		
Are you allergic to penicillin?	☐ Yes ☐ No	Are you a smoker?	☐ Yes ☐ No	If yes, approx. how many/day?……	

Do you have any other allergies? ☐ Yes ☐ No If Yes, please list ……

Heart Trouble of any Kind ☐ Yes ☐ No If Yes, please detail ……

Bleeding or Blood Disorders ☐ Yes ☐ No If Yes, please detail ……

Are you currently taking any medicines, tablets and/or supplements? ☐ Yes ☐ No If yes please list: ……

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Any other serious illness? ☐ Yes ☐ No If Yes, please detail ……

Any particular adverse reaction to previous dental treatment? ☐ Yes ☐ No If Yes, please detail ……

Is there any other comment you wish to make in regard to your dental treatment?

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Are you of Aboriginal or Torres Strait Islander heritage? ☐ Yes ☐ No Women: Are you pregnant? ☐ Yes ☐ No

Name…… Signature: …… Date: …… / …… / 20……