NEW PATIENT FORM

Title Dr / Mr / Mrs / Ms / Miss / Master /Other

Surname_____Name_____

Date of birth ___/___/ _____ Preferred name _____

Address_____Postcode_____

Phone (M) _____ (H) _____ (W) _____

Email _____Occupation_____

Emergency Contact _____Relationship to patient _____ Contact # _____

Health Fund _____ Membership # _____ Patient ID_____

Medicare Card # _____ Patient ID _____ Expiry _____

Pension / Healthcare Card _____ Date of Issue_____ Expiry _____

Veterans' Affairs Card # _____ Workers Comp Claim # _____

Who is your GP? _____ Phone: _____

When was your last dental visit? _____
Have you had any orthodontic analysis or treatment? _____
Have you had any dental extraction e.g. wisdom teeth removal / when? _____
Have you been prescribed Bisphosphonates e.g. Fosamax, Prolia, Zometa, Actonel or other_____

Whom may we thank for recommending us? _____

_____

Medical Questionnaire – Private and Confidential
Please answer these questions fully. Information about your medical history is for your dentist's use only.

Past/Current medical conditions:
Are you receiving any medical treatment at present Y / N Details _____
Have you had any serious or long standing illness Y / N Details _____
Have you ever been hospitalised Y / N Details _____
Are you pregnant / Breastfeeding YES /NO Details _____

Have you previously received any of the following? If so please list the date, product, dosage used.
Botox/ Dysport/ Dermal Filler Injections _____
Facial Treatments – e.g. Threadlift, laser, microdermabrasion, skin needling _____
How often do you apply Sunscreen? _____

Please tick if you have received the following in the last 3 months:
Antibiotics – notably spectinomycin or aminoglycosides : _____
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS): _____
Anti-coagulant therapy – e.g. Warfarin, Heparin, Aspirin: _____
Health Suppliments – e.g. VitaminE, Omega-3 Fish Oils: _____

Any Other Medication eg Roaccutane

Please indicate below if you have had, or have at present any of the following: (PLEASE CIRCLE)

RHEUMATIC FEVER / HEART MURMUR	YES / NO	**PHYSICAL / MENTAL DISABILITY**	YES / NO
HEART VALVE DAMAGE	YES / NO	**CANCER**	YES / NO
HEART ATTACK / ANGINA	YES / NO	**RADIOTHERAPY / CHEMOTHERAPY**	YES / NO
HEART SURGERY / PACEMAKER	YES / NO	**EXCESSIVE BLEEDING / BLOOD DISORDER**	YES / NO
HIGH / LOW BLOOD PRESSURE	YES / NO	**JOINT REPLACEMENT SURGERY**	YES / NO
CHOLESTEROL	YES / NO	**PREGNANCY**	YES / NO
STROKE	YES / NO	**SMOKER**	YES / NO
EPILEPSY	YES / NO	**ORAL HERPES**	YES / NO
THYROID DISORDER	YES / NO	**ACTIVE TB**	YES / NO
DIABETES	YES / NO	**HEPATITIS A B C**	YES / NO
ASTHMA /BRONCHITIS / HAYFEVER	YES / NO	**HIV / AIDS**	YES / NO
LUNG DISORDER	YES / NO	**OTHER**	YES / NO
KIDNDEY / LIVER DISORDER	YES / NO	**CHILD IMMUNISATIONS UP TO DATE ?**	YES / NO

Do you have any Allergies - e.g. PENICILLIN _____
Please list Medications _____
_____

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 anesthetic and other medication as indicated.

I agree that the above is a true and accurate record. Please note this form is a guide only and you should discuss any relevant matters with my dentist prior to the commencement of any dental treatments. Please see our website for our privacy statement.

I understand that St Mark Group require payment on the day of treatment.

We provide a courtesy to our patients of a preventive recall program that offers a reminder to you if you have not attended the practice in 6 months. (Please indicate here to opt out)

SOCIAL MEDIA RELEASE
I, the undersigned, do hereby grant permission to St Mark Group to post my and/or my child's story, photo, or other item, hereinafter referred to as "Materials,". I submit to and for St Mark Group's Web site, Instagram account (@StMarkGroup), and Facebook account. (Please indicate here to opt out)

X Signature _____ Date ____ / ____ / _____

PLEASE NOTE:
We are happy to reschedule your appointment when necessary, please advise us 24 hours prior of any reschedule or cancellation requirements. As you may incur a fee of $75.00 for unattended appointments.

The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

X Signature _____ Date ____ / ____ / _____

OFFICE USE ONLY- Form checked by _____ Data keyed by _____ Form scanned by _____