Colgate AUSTRALIAN CLINICAL DENTAL RESEARCH CENTRE

Professional Suites

NEW PATIENT INFORMATION

SURNAME .... TITLE .... GIVEN NAMES ....

DATE OF BIRTH...

ADDRESS ....

SUBURB .... P/CODE .... EMAIL ....

HOME ☎ .... WORK ☎ ....

MOBILE ☎ .... FAX ☎ ....

OCCUPATION .... REFERRED BY ....

DENTAL COVER PROVIDER (HEALTH FUND) ....

IS THIS VISIT RELATED TO AN INSURANCE/WORKCOVER CLAIM? IF SO PLEASE PROVIDE CONTACT DETAILS OF COMPANY HANDLING CLAIM ....

MEDICAL PRACTITIONER ....

EMERGENCY CONTACT .... ☎ ....

Have you ever stayed in hospital or had an operation? Yes/No

If so, please give details...

Do you have any allergies? Please list .... Yes/No

Have you ever had any type of heart disease, high blood pressure or rheumatic fever? Yes/No

If so, please give details...

Do you have diabetes? Yes/No

Have you ever had tuberculosis, asthma or other lung diseases? Yes/No

Have you ever had hepatitis or any other liver disease? Yes/No

Do you have any bleeding problems or blood disorders? Yes/No

Have you ever been tested for HIV? Yes/No

Are you pregnant? (Women of childbearing age only) Yes/No

Do you have any other medical problems? Please list .... Yes/No

Are you currently on any medication? Please list .... Yes/No

Do you suffer from bad breath? Yes/No Would you like this investigated further? Yes/No

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Signature of Patient Date

PAYMENT IS REQUESTED AT TIME OF TREATMENT
HICAPS, EFTPOS AND CREDIT CARD FACILITIES ARE AVAILABLE FOR YOUR CONVENIENCE
24 HOURS NOTICE IS REQUIRED FOR ALL APPOINTMENT CANCELLATIONS