DUNSTAN DENTAL & MEDICAL

New Patient Information Form

Your first consultation is usually scheduled for up to 1.5 hours [if needed] to allow the doctors to create a comprehensive medical file and explore your health problems in detail. The duration of follow up appointments will depend on your health problem(s). They may range from 15-30-45 minutes. Your doctor will decide with you when they would like to review you again. Please bring any specialist reports, investigations or tests you had with previous doctors that may be useful for our doctors to view. Parking is available at the rear of the practice. Please arrive 15 minutes before your appointment and bring your completed registration form for the doctor to view.

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following?

Surname			
First Name			
Date of Birth:			
Street Address			
Suburb & Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Medicare Number		**Expiry Date**	
DVA Gold / White (Please circle)		**Expiry Date**	
Pension Number		**Expiry Date**	
Health Care Card Number		**Expiry Date**	
Private Health Cover			
Next of Kin (Name and Phone number)			
Emergency Contact (Name and Phone number of the person we can contact if needed)			
Ethnicity **Country of Birth**			

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, breast checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

☐ Yes ☐No

If we need to contact you what is your preferred method of contact:

☐ Phone ☐ Mail

Can we text reminders for appointments on your mobile phone?

☐ Yes ☐No

Do you have any health concerns you would like to receive more information on?

To assist with health initiatives - Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes ☐ No

Please list your Health History in order from childhood to adulthood/CURRENT:

Disease / operation / health problem:	Year or date when this health problem occurred:

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ALLERGIES

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes (If yes please list below) ☐No

____

____

Immunisations - Have you had the following immunisations?

Tetanus booster	date__________	☐ Don't Know	☐ Haven't had one
Hepatitis B	date__________	☐ Don't Know	☐ Haven't had one
Hepatitis A	date__________	☐ Don't Know	☐ Haven't had one
Influenza	date__________	☐ Don't Know	☐ Haven't had one
Pneumococcal	date__________	☐ Don't Know	☐ Haven't had one
Polio	date__________	☐ Don't Know	☐ Haven't had one

Children's Immunisations - If completing this form for a child is their immunisations up to date?

☐ Yes ☐No

Current Medications (including over the counter medications, vitamins and minerals)

____

____

____

____

____

Family History - Please list if there are any health problems for each family member:

1. Mother - is she alive? **YES / NO**

Please list any health issues:____

2. Father - is he alive? **YES / NO**

Please list any health issues:____

3. Brothers:____

4. Sisters: ____

5. Grandparents [maternal and paternal]:

Maternal:____

____

Paternal:____

____

Social History

☐ Tobacco: ________ day / week or Ceased Smoking - date ____________

☐ Alcohol: ________ day / week / month (circle the one applicable)

☐ Drug use [past/present]____________________________________ (type and frequency)

Height: __________ cms **Weight:** _____________ kgs

Year of last PAP smear & result of that smear [women]: