Goodlife DENTAL STUDIO

New Patient Information Form

Patient Details

Full Name:	
Date Of Birth:	
Occupation:	
Phone:	
Address:	
Email Address (please write clearly):	
Medicare Card **(Only for kids)**	Ref:

Emergency Contact Details

Name:
Phone:
Relation:
If you elect not to provide an emergency contact, please notify staff.

Dental History

When was your last dental visit?
What was it for?
Reason for your appt today?

How did you first hear about us?

Location	Online	Facebook	Word of Mouth
Reputation	Instagram		
Who should we thank for referring you?			
What made you decide to come to our practice?			
Is there anything that we can do to make your experience more enjoyable? Can the staff do anything to help if you are feeling anxious during your visit? _____ _____ _____			

By signing below, you declare that the information you have provided is true and correct and that you understand it is possible that certain anonymized dental records including, but not limited to dental photographs, models and radiographs may be used for educational, research and/or marketing purposes by Goodlife Dental Studio Pty Ltd and/or your Dental Healthcare Provider. This is a condition of treatment at this practice. I agree to be responsible for payment of all services/treatment rendered on my behalf and on behalf of my dependent. I understand that payment is due at the time of service unless other arrangements have been made. A cancellation fee may be applied if less than 48 hours' notice is given. If you have any concerns, please discuss this with staff prior to signing.

Sign: _____ Date: _____/_____/_____

Medical History

Medications *(inc: vitamins, minerals and supps)*	**YES / NO**
Allergies:	**YES / NO**

Do you currently have or history of:		**Please include relevant details**
Smoker (E-cig, cigars, vape etc)	YES / NO	
Heart Problem	YES / NO	
Blood Disease / Bleeder	YES / NO	
Rheumatic Fever	YES / NO	
HIV	YES / NO	
Diabetes	YES / NO	
Blood Pressure Problem	YES / NO	
Epilepsy	YES / NO	
Asthma	YES / NO	
Lung Problem	YES / NO	
Kidney Disease	YES / NO	
Bone Disorder	YES / NO	
Radiation	YES / NO	
Chemotherapy	YES / NO	
Cancer	YES / NO	
Osteoporosis	YES / NO	
Thyroid Problem	YES / NO	
Reflux / Heartburn	YES / NO	
Cholesterol	YES / NO	
Mental/Behavioural Illness	YES / NO	
Pregnant or breastfeeding?	YES / NO	
Other		

Office Use Only	Staff Sign	NRAKKAS	Provider Initial
	Input into Ultimo	HMcV	