Patient Information

Please complete the details on this page and answer the questions on the Medical History Form.
It will assist us greatly to provide the best treatment for you.

Mr Mrs Ms Miss Other Surname First Name

Phone Number Email

Date of birth

Centrelink Entitlement **YES** **NO** Details

Dept. Veterans Affairs **YES** **NO** Details

Private Health Fund **YES** **NO** Details

FAMILY CONTACT DETAILS

Name Relationship

Phone Number (H) (W) (M)

Address

Secondary Contact Name

Phone Number (H) (W) (M)

CONSENT NURSING HOME AND HOSTEL RESIDENTS ONLY

Please note a consent form must be completed prior to dental exam and/or emergency treatment

Name of person authorised to give consent for dental examination and treatment

Phone Number (H) (W) (M)

Relationship of authorised person to patient ☐ **Self** ☐ **Next of Kin** ☐ **Guardianship Board** ☐ **Public Guardian**

Please note under the Guardian Act 1987, consent cannot be given by paid carers in nursing homes or hostels