McCrae | Marong | Strathfieldsaye
DENTAL PRACTICE

Bendigo
168 McCrae St
(03) 5441 6040

Marong
51 Goldie St
(03) 5441 6202

Strathfieldsaye
955 Wellington St
(03) 5439 4777

E reception@mccraedental.com.au
W www.mccraedental.com.au

NEW PATIENT FORM

Patient medical history

Title: Mr | Mrs | Miss | Other _____ Home phone _____

Given name _____ Mobile phone _____

Surname _____ Email address _____

Home address _____

Medical health fund _____ Dental health fund _____

Name of doctor _____ Doctors phone _____

Doctors address _____

Next of kin _____ Next of kin phone _____

Relationship to patient _____ Person responsible for account _____

Have you ever had any of the following? (please tick)

Heart condition	☐ YES / ☐ NO	Kidney disease	☐ YES / ☐ NO
Thyroid problem	☐ YES / ☐ NO	High blood pressure	☐ YES / ☐ NO
Rheumatic fever	☐ YES / ☐ NO	Stomach or bowel problems (eg ulcers)	☐ YES / ☐ NO
Epilepsy	☐ YES / ☐ NO	Infectious disease (HIV, AIDS, TB)	☐ YES / ☐ NO
Diabetes	☐ YES / ☐ NO	Lung disease or breathing problems	☐ YES / ☐ NO
Anaemia	☐ YES / ☐ NO	Are you currently pregnant	☐ YES / ☐ NO
Hepatitis	☐ YES / ☐ NO	Do you have an artificial hip, heart valve,	
Asthma	☐ YES / ☐ NO	or other prosthetic implant	☐ YES / ☐ NO

Have you had any operations, and in what year? (please list) _____

Are you taking any drugs, medications, supplements? (please list) _____

Do you have any allergies? (please list any drugs, medications, materials, or foods you are allergic to)

_____

How did you hear about us? (please tick)

☐ Friend or family member ☐ Internet ☐ Radio ☐ Newspaper ☐ Other _____

Signature _____ Date _____

PLEASE NOTE: It is policy of the practice that we have payment on the day of treatment. If you are unable to pay today please let reception know before your appointment as your appointment may have to be rescheduled to another day. Thank you.