PATIENT HISTORY

In order for this practice to provide the highest standard of care, it is requested you fill in this form carefully and thoroughly.

Title: Miss / Mrs/ Ms / Mst / Mr / Dr / Other............. **First Name/s**: ....

Surname: .... **Date of Birth**: ....

Home Address: ....

Phone.. **Mobile**.. **B/H Phone**..

Email:..

Postal Address (if different from above) ....

Name of person responsible for fees...

Address (if different from above) ....

Emergency Contact 1.. **Relationship**... **Ph**.................................

Emergency Contact 2 ....**Relationship**:...**Ph**:...

DENTIST NAME: .... **Ph**..

Address .... **P/Code**.......................

Medical Doctor: .... **Ph**..

Address ....**P/Code**.......................

Do you have a health fund? **NO** **YES** (If so, please list fund)...

Who recommended our practice to you?..

How did you find us: **Google** **Facebook** **Instagram** **Yellow pages** **Other**...

Do any other family members attend our practice?..

Do you have any hobbies or interest?..

What school do you attend? .... **What Year Level**?......................................

Dr Barbara Carach BSc, BDSc, Grad Dip Clin Dent, MDSc (Melb)
175 Warrandyte Road, Ringwood North, Vic 3134
Phone: 9876-1677 Fax: 9876-1660