**NEW PATIENT REGISTRATION FORM**

□ Mr □ Mrs □ Ms □ Miss □ Master □ Dr □ Other \_\_\_\_

Surname .............................................................. First Name........................................................................................

Date of Birth ............/............/............ Occupation …………………………………………..……………………………………..

Postal Address ................................................................................................................................................................

Suburb ............................................................. Postcode .............

Phone number ...............................................................

Email address ...................................................................................

Medicare Number \_\_ \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ \_\_ - \_\_ Line (No. before name) \_\_ Expiry \_\_ / \_\_\_

Private Health Insurer .......................................................... Member No. ...........................................................

**Emergency Contact / Next of Kin**

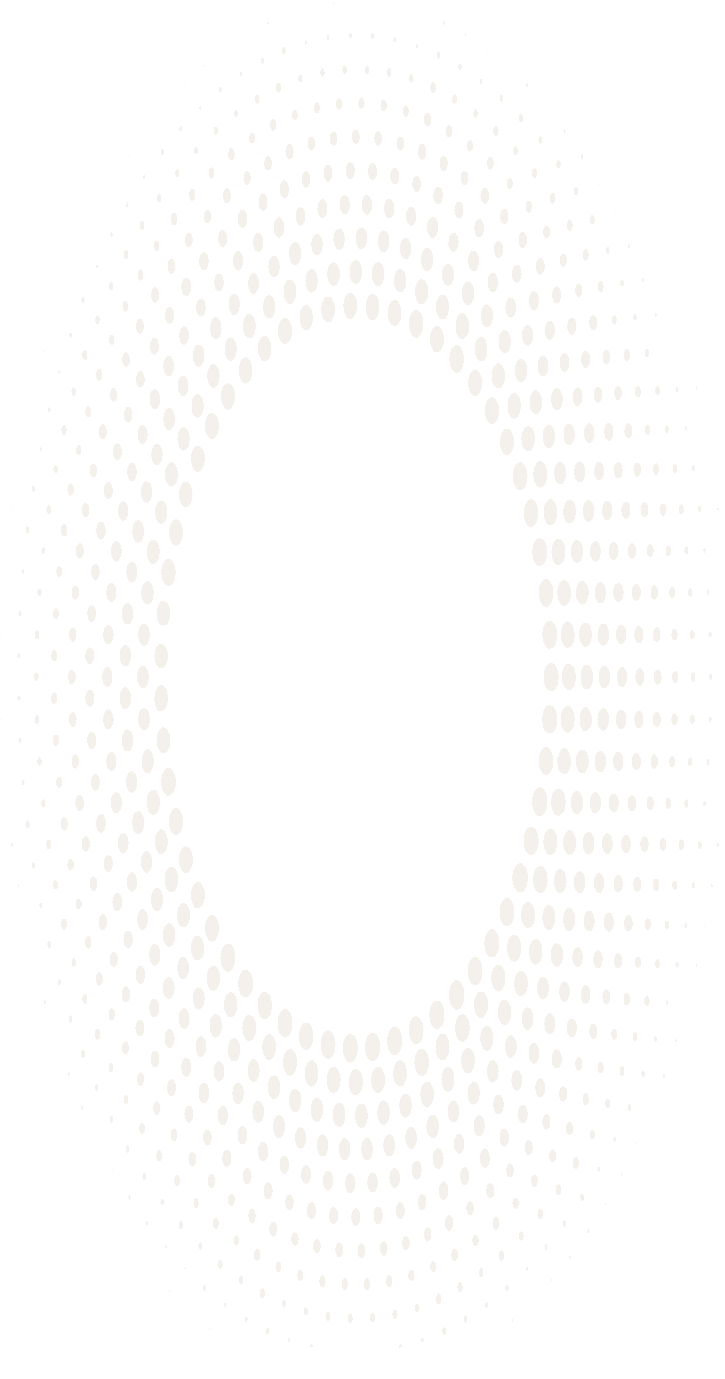
First Name ............................................................................ Surname .......................................................................

Relationship to Patient ......................................................... Mobile Number.............................................................

***Patients under 18yrs or under Parent Medicare Card***

*Guardian full name................................................................ Guardian DOB. ................../................./......................*

*Guardian Medicare number .................................................. Reference number ................Card Expiry: ……../….…..*

*Guardian email address*……………………………………………………..

**PLEASE FILL OUT BACK PAGE**

**MEDICAL HISTORY**

Have you had any serious illness, operation, or hospitalisation?

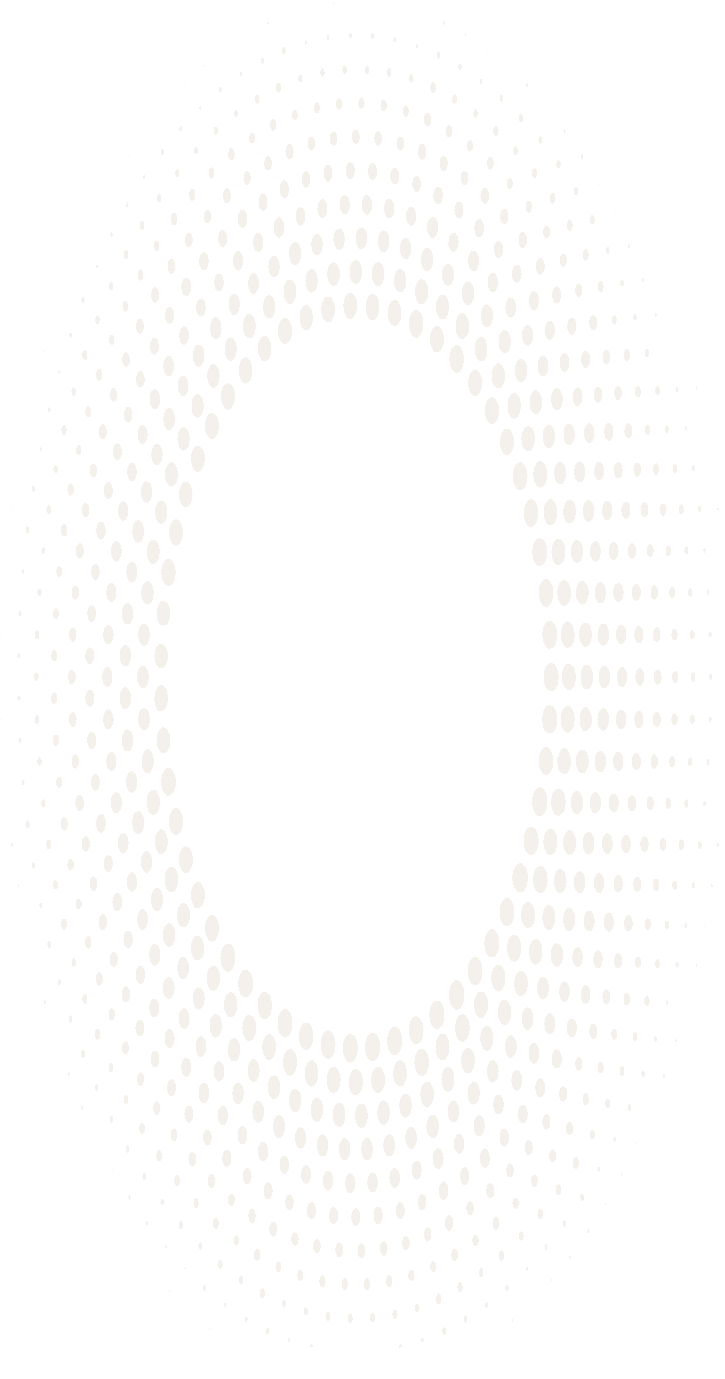
………………………………………………………………………………………………………………

Are you taking any medicine(s), non-prescription, vitamins, or natural remedies?

………………………………………………………………………………………………………………

Are you taking or have you ever taken Bisphosphonates (i.e. Prolia, Fosamax, Actonel, or Zometa) ?

………………………………………………………………………………………………………………

**Please tick any applicable conditions and specify if you answer yes to the following:**

* Heart condition (including any valves, artificial valves, pacemaker, or heart murmur) ………………………………………..
* Blood disorder such as anaemia or haemophilia ………………………………………………………………………………………………….
* Asthma
* Diabetes – Type 1 / Type 2
* Hepatitis, jaundice, liver disease …………………………………………………………………………………………………………………………..
* Thyroid problems ………………………………………………………………………………………………………………………………………………….
* Osteoporosis
* Artificial joint replacement (knee, hip, shoulder, etc.) …………………………………………………………………………………………..
* Anxiety, depression, or mental health condition …………………………………………………………………………………………………..
* Neuromuscular condition (e.g. Myasthenia Graves or Lambert-Eaton) …………………………………………………………………
* Cancer …………………………………………………………………………………………………………………………………………………………………..
* Radiation therapy to head, neck, jaw …………………………………………………………………………………………………………………….
* Allergies …………………………………………………………………………………………………………………………………………………………………

Do you smoke or vape? …………………………………………………………………………………………………………………..

Do you consume alcohol? ……………………………………………………………………………………………………………….

Do you consume any illicit substances? ……………………………………………………………………………………………

Are you pregnant, nursing, or trying to become pregnant? ………………………………………………………………

**CONSENT**

I consent to the collection of my personal and health information in accordance with the Australian Privacy Act including the use of AI-powered scribe to assist in documenting my medical history, treatment details and other important information during my consultation and treatment. I have properly disclosed my personal details and medical history. I understand the information provided will be kept confidential and may be used in the following ways.

* Billing and administrative purposes including compliance with Medicare Australia
* Disclosure to other health care professionals, including treating doctors & specialists outside this medical practice. This can occur through referral to other doctors and referral for medical tests.
* I have read and understand this whole form. I understand it is my responsibility to fill out the form correctly and accurately.
* Clinical images may be used for teaching purposes and are deidentified.

Patient/Guardian Signature: ..................................................... Date ...............................