New Patient Information – Child

We at Seascape Dental are committed to excellence in dentistry and appreciate you taking the time to complete this confidential form. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us and we will be happy to help.

About Your Child

Full Name _____Male / Female DOB _____

Home Phone _____ Work Phone_____

Email_____

Guardian Name_____Emergency Phone_____

Address_____

Suburb_____Postcode_____State_____

Dental Health Fund_____#_____Ref#_____

Medicare #_____Ref#___ Expiry Date_____

Please note: Reference number (Ref#) refers to the allocated number next to your name.

Preferred Method Of Contact Telephone ☐ SMS ☐ Email ☐ Letter/Mail ☐

Medical Doctor Details

Doctor's Name _____Phone # _____

Address _____

Suburb_____Postcode_____State_____

Medical History Information

Ever been hospitalised ☐ No ☐ Yes

If yes, explain _____

Medications being taken ☐ No ☐ Yes

If yes, explain _____

Is under the care of a Doctor ☐ No ☐ Yes

If yes, explain _____

Known allergies ☐ No ☐ Yes

If yes, explain _____

Ever Suffered From:

Please tick answer	No	Yes	If YES please provide details:
Epilepsy	☐	☐	_____
Heart Condition	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____

Does your child have any other important health issues?
No ☐ Yes ☐ _____

How did you hear about us/Who can we thank?

_____

- I agree to be responsible for payment of all services rendered on my behalf and I understand that payment is due at the time of service unless other arrangements have been made.
- We have *HICAPS* for processing private health insurance claims.
- Please note, when claiming is not possible due to issues with your health fund, as per practice policy, accounts will need to be paid in full at your appointment. We accept Visa, Mastercard, *EFTPOS* and cash.

Patient Guardian Signature _____ Date _____

Dr Adam Barrett
#4739871L

Dr Carla Morassi
#4755121H