

New Patient Form



The accuracy of this information is important. Thank you for completing this questionnaire with care. Be assured that all the information you provide is kept strictly confidential.

Title _____ First names _____ Surname _____

Postal Address _____ Postcode _____

Telephone: Home _____ Work _____ Mobile _____

Email _____ Date of birth _____ Occupation/School _____

I wish to receive emails and texts that include appointment notifications, news or promotions

Name and contact of Parent/Guardian (if appropriate) _____ Are they responsible for your fees? Y / N

Name and contact of next of kin _____

How did you hear about us ? (Please circle) TV Magazine Newspaper Website/Websearch Brochure Yellow Pages Book Street Sign

Word of mouth (Please name) _____ Other _____

Name of last dentist _____ Year of last visit _____

Have you had: Orthodontic Treatment Gum Treatments Your bite adjusted Prolonged bleeding after tooth extractions

A bad dental experience A fear of seeing a dentist The need to take antibiotics prior to dental treatment

Please tick if you have any concerns regarding the following:

Appearance of your teeth Your ability to chew Teeth cleaning technique Existing dental fillings or restorations

Bad taste or bad breath Clicking or pain in jaw Bleeding gums Teeth tender to bite on

Clenching or grinding Sensitivity Dry Mouth Food traps

Interested in whiter teeth Interested in straighter teeth

How would you rate your teeth now? 1 2 3 4 5 6 7 8 9 10 What are you expectations for your new smile? 1 2 3 4 5 6 7 8 9 10

Name of medical practitioner _____ Location _____

Are you currently receiving medical treatment or taking any drugs or medicine including oral contraception or blood thinning medicine? If so please list _____

Have you any allergies to medicines, anaesthetics, latex, penicillin or contact allergies? If yes please list _____

Are you a smoker? Y / N Are you, or could you be pregnant? If yes how many months? _____

Please tick if you have or have had any of the following:

Anaemia Depressive Illness Heart Murmur Nervous Problems Rheumatic Fever

Arthritis Diabetes Hepatitis A, B, C, D Osteoporosis Severe Headaches

Asthma Epilepsy/Seizure High Blood Pressure Pacemaker Stroke

Cancer/Malignancy Excessive Bleeding or Bruising Low Blood Pressure Prosthetic Joint Tuberculosis

Chest Problems Gastric Problems HIV/AIDS Radiotherapy Hearing/Sight Impairment

Cold Sores Heart Condition (List below) Liver or Kidney Problems Reaction to Anaesthetic

If you have ever had a heart condition, please specify _____

Are there any other aspects regarding your health that you think your dentist should know about? _____

CONSENT FOR TREATMENT: I authorise the dentist/designated staff to perform all recommended treatment deemed appropriate by the dentist to make a thorough diagnosis. I agree to be responsible for payment of all services rendered. I understand that payment is due at time of service. Cost incurred in relation to collection of overdue accounts will be charged to the account holder. By signing below I understand and accept these terms and conditions.

Signed by Patient/Parent/Guardian _____ Date _____

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, EFTPOS AND MAJOR CREDIT CARDS. FINANCE OPTIONS AVAILABLE.

Patient Update Form



Please update the information that has changed since your last visit with us. Thank you for completing this questionnaire with care. Be assured that all the information you provide is kept strictly confidential.

Title _____ First names _____ Surname _____

Postal Address _____ Postcode _____

Telephone: Home _____ Work _____ Mobile _____

Email _____ Date of birth _____ Occupation/School _____

I wish to receive emails and texts that include appointment notifications, news or promotions

Name and contact of Parent/Guardian (if appropriate) _____ Are they responsible for your fees? Y / N

Name and contact of next of kin _____

Name of medical practitioner _____ Location _____

Are you currently receiving medical treatment or taking any drugs or medicine including oral contraception or blood thinning medicine? If so please list _____

Have you any allergies to medicines, anaesthetics, latex, penicillin or contact allergies? If yes please list _____

Have you been advised you need to take antibiotics prior to dental treatment? Y / N

Are you a smoker? Y / N Are you, or could you be pregnant? If yes how many months? _____

Please tick if you have or have had any of the following:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Depressive Illness | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A, B, C, D | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer/Malignancy | <input type="checkbox"/> Excessive Bleeding or Bruising | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prosthetic Joint | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Problems | <input type="checkbox"/> Gastric Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Radiotherapy | <input type="checkbox"/> Hearing/Sight Impairment |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Condition (List below) | <input type="checkbox"/> Liver or Kidney Problems | <input type="checkbox"/> Reaction to Anaesthetic | |

If you have ever had a heart condition, please specify _____

Are there any other aspects regarding your health that you think your dentist should know about? _____

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