# New Patient Form

## Personal Information

Surname First Name Title
Preferred name D.O.B. …. /…../……..
Address ……
Phone Number …… Work……
Mobile Number …… Email ……
Occupation ……

## Emergency Contact

Name ……..
Relationship to you……..
Address …….
Contact Phone …… Email……
Person responsible for fees ……..
Do you have dental insurance benefits? If so, please specify the provider's name…….
Please tell us how you discovered our surgery……..

## Medical History

Who is your medical doctor/specialist? ……
Address ……
Are you presently under the care of a medical doctor? (If yes, what condition is being treated?) ……
Are you presently taking any medication? (If yes, what medications are you taking?) ……

Have you ever had any allergic reaction to any medication?
……
Have you ever been hospitalised or had any serious health problems during the past year? If yes, what was the problem?
……
Are you, or is there any possibility that you are pregnant?
Yes No option tick

If yes, approximately how many months?……
Are you Aboriginal or Torres Strait descent?
Yes No option tick

Please tick if you have, or had any of the following. multiple option tick, and arrange 3 per row if possible, otherwise whatever fits the screen size
Rheumatic fever or heart disease
Heart murmur
Congenital heart disease

Heart trouble
Heart attack
Stroke
Previous infective endocarditis
Pacemaker
Prosthetic or artificial heart valve, repair, replacement
Organ transplant
High blood pressure
Low blood pressure
Blood disease
Known bleeder
Taking a blood thinner
Hepatitis
HIV
Blood transfusion
Asthma
Respiratory problems
Tuberculosis
Diabetes
Thyroid condition
Arthritis
Allergy / Hypersensitivity
Epilepsy / Fits
Cancer/Chemotherapy
Radiation therapy
Bone disorders
Bone medications (bisphosphonates)
Osteoporosis
Prosthetic or Artificial joint(s)
Stomach problems
Kidney Disease

Do you smoke? If yes, how many per day? ……
Other health problems not listed
……
**Oral Health History**
My major concern for today's visit is ……
When was the last time you received dental treatment?
……
Have you had any trouble with any previous dental treatment?
……
Please tick if you experience any of the following. multiple option tick, and arrange 3 per row if possible, otherwise whatever fits the screen size
Toothache
Swelling on your gum around a tooth
Sensitivity to Hot
Cold

Sweets
Biting pressure
Bleeding gums
Concern with your breath
Loosening teeth
Drifting teeth
Missing teeth
Denture problems
Broken tooth
Lost filling
Decay (cavity)
Grinding/Clenching
Worn teeth
Jaw joint clicking
Jaw joint pain
Food catching between your teeth
Are you dissatisfied with the appearance of your teeth?
Discolouration
Crowding
Spaces / Gaps
Crooked teeth/ Chipped teeth
Other

as a tick box:

I agree that the above is a true and accurate record.

- I have read and understood the PRIVACY CONSENT DOCUMENT and consent to the collection and use of my health information.

Note: link PRIVACY CONSENT DOCUMENT' to privacy page to be built later