New Patient Form

Title *

○ Mr. ○ Mrs ○ Ms ○ Other

Surname *

First Name *

Preferred name *

DOB *

dd/mm/yyyy

Best phone number *

Email Address *

Postal address *

How did you hear of us? (Please Select following) *

Select

Other

Were you referred? *

○ Yes ○ No

EMERGENCY CONTACT DETAILS

Relationship to the patient *

Emergency contact number *

Email *

MEDICAL FORM:

Current medical doctors name *

Contact number *

Practice name *

Are you receiving any medical treatment at the moment? If yes, please describe

1. Current medications (prescription/over the counter)

1.Medication	1.illness/disease
2.Medication	2.illness/disease
3.Medication	3.illness/disease
4.Medication	4.illness/disease

2. Current supplements taken (please list)

3. Smoking status:

○ Current ○ Past

Approx how many each day?

4. Do you drink alcohol? *

○ Yes ○ No

5. Allergy to medications/antibiotics/lates or other *

○ Yes ○ No

Details

6. Do you have or have had the following?

- ☐ Heart complaint/treatment
- ☐ High or low blood pressure
- ☐ Anti coagulant therapy
- ☐ Epilepsy
- ☐ Steroid therapy
- ☐ Tuberculosis
- ☐ Mental health/depression/anxiety
- ☐ asthma/bronchitis/lung conditions
- ☐ Thyroid disease
- ☐ Jaundice or other liver disease
- ☐ Arthritis
- ☐ Bisphosphonate medications
- ☐ Diabetes
- ☐ Rheumatic fever or heart valve surgery
- ☐ Blood disorders
- ☐ Osteoporosis or bone disease
- ☐ Hiv or blood borne viruses
- ☐ Stroke
- ☐ Any nervous system disorder
- ☐ Gastric ulcer/digestive conditions
- ☐ Radiation therapy/chemotherapy
- ☐ Hepatitis - A, B, C .....
- ☐ Transplanted organ or bone marrow
- ☐ Kidney disease
- ☐ Joint replacement surgery

DENTAL HISTORY

When was your last dental examination and hygiene clean? *

Are you currently experiencing pain or have a specific dental problem? *

Are you wearing a dental appliance *

Have you any dental implants? *

Do you have bleeding gums or ever been diagnosed or treated for gum diseases? *

Is there anything else you would like to talk to your oral health therapist about? *

PAYMENT TERMS

Person responsible for the account:

☐ Is the patient ☐ Other

Name *

Relationship to patient *

Best Contact Number *

Email *

Address *

☐ I understand that Dental in Residence requires payment on the day of treatment with their onsite payment system or account transfer.

☐ I will expect a receipt of services that i can take to my health insurer for rebate.

CONSENT

☐ I AGREE the above is a true and accurate record

☐ I consent to the above forms being embedded into my personal file and kept securely with Dental in Residence

☐ I consent to an initial examination whereby a treatment plan will be outlined to me in written form.

Send