

# New Patient Form

Title \*

Mr.  Mrs  Ms  Other

Surname \*

First Name \*

Preferred name \*

DOB \*

Best phone number \*

Email Address \*

Postal address \*

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

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?

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

## 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 services provided by Dental in Residence are not covered by Medicare. If I have private health insurance with dental cover, part or all of the treatment fee may be covered depending on my level of cover.

I understand that I'm able to pay through the portable payment doc and then I'm able to claim through my health fund via their app or website.

## 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

Send

We will attend in the comfort of your armchair or bed ensuring we can meet your needs and work together to improve your oral health and overall general health.



## CONTACT US

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