



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)*

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, 8, 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*

PRIVATE HEALTH FUND

Name of Your Private Health Fund

Membership Number

Card Expiry Date

- ☐ 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 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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📄 NEW PATIENT FORM

