DENTAL AT HEALTH PRECINCT – NEW PATIENT AND MEDICAL HISTORY FORM

Welcome to the Health Precinct. Your information disclosed below, will be kept confidential and is necessary for us to provide you with optimal dental treatment.

Surname: ______________________ Title: ______ First Name: ______________________

Preferred Name: ______________________ DOB: ___/___/___ Gender M/F

Health Fund: ___________ Member Number: ________________ Reference Number: ____

Medicare Number: __________________________ Reference Number: ____

Address: ____

Suburb: ________________________ Post Code: _______________

Phone (Home): _______________________ Phone (Mobile): ________________________

Phone (Work): ______________________ Email: _________________________________

Emergency Contact: _________________________ Number: ________________________

For minors, person responsible/parent/guardian: __________________________________

MEDICAL HISTORY

Have you ever had/have any of the following? Please (x) those applicable:

Arthritis		Anaemia		Asthma		Artificial Joints	
Anxiety		Blood Pressure		Bleeding Disorder		Cancer	
Diabetes		Emphysema		Epilepsy/Seizures		Heart Surgery	
Heart Attack		Heart Complaints		Hep A/B/C		Contact HIV/AIDS	
Kidney Disease		Liver Disease		Sinusitis		Rheumatic Fever	
Stomach Ulcers		Stroke		Thyroid		Tuberculosis	
Osteoporosis		Pacemaker		Depression		Chemotherapy	

If other, please specify: _________________ Are you taking fish oil/blood thinners? YES/NO

Your GP: _____________________ Clinic Details: ________________________________

List of current medications: ____

Do you have any allergies? ____

Smoking status: YES/NO If yes, how many per day? __________________________

Pregnancy Status (females only): ____

Do you require antibiotics prior to dental procedures? YES/NO

DENTAL HISTORY

What brings you to our practice today? ____

When was your last appointment? ____

Please (x) if any of the following apply to you:

Scale/Clean		Tooth Ache		Sensitivity		Holes in Teeth	
Lost Filling		Face/Jaw Pain		Bleeding Gums		Discoloured Teeth	
Straightening Teeth		Loose Teeth		Bad Breathe		Grinding Teeth	

How comfortable are you with the dentist? Please circle:

Easy   Slightly Uneasy   Moderately Stressed   Very Nervous

How did you find out about us?

Google		Friend Referral		Staff Referral		Facebook	
Front signage		Walking By		Billboard		Flyers	

We would love to thank the person who referred you. Who was it? ______________________________

Consent for Services

I the undersigned, fully consent to the performing of dental procedures that are mutually agreed to be necessary or advisable. I also consent the practice to use my records such as photographs and models for internal usage, diagnosis and treatment planning only.

I understand that the practice needs a minimum of 24 hours' notice to cancel my appointment, if less than this, a cancelation fee may apply. I am aware that payment is required in full at the time of my appointment/prior to completion of treatment.

We provide a courtesy message to all our patients that offers as a reminder service for appointments. I consent to use my mobile number/email address or sending reminders, confirmation messages and special offers.

I declare that my appointment was made out of my own choice and will.

Patients signature: ______________________________________ Date: ________________________

Medical History reviewed: _________________________________ Scanned: ________________________

Thank you for choosing the Health Precinct.