NEW FARM DENTAL STUDIO.COM.AU

NEW PATIENT INFORMATION

PERSONAL DETAILS

Title: _____ Surname: _____

First name: _____ Preferred name: _____

Date of Birth: _____ Occupation: _____

Address: _____

_____

Phone - Home: _____ Mobile: _____

Email:_____ Private Health Fund: _____

Emergency contact: _____

Medical doctor's name / Practice: _____

How did you hear about our practice? _____

Which one of our valued patients can we thank for referring you? _____

MEDICAL HISTORY

Are you currently taking any medication or drugs? -- Select --

If yes, please give details _____

Have you had any drug allergies, or anaphylaxis? -- Select --

If yes, please give details_____

Have you had any recent or planned surgery? -- Select --

If yes, please give details_____

Are you pregnant? -- Select -- If yes, how many weeks? _____ Are you nursing? -- Select --

Is there anything you would like to discuss privately with the dentist? _____

_____

Heart problems	-- Select --
High / Low blood pressure	-- Select --
Diabetes	-- Select --
Rheumatic fever / Valve replacement	-- Select --

Kidney or Liver disorder	-- Select --
Reflux, crohns, ulcerative colitis	-- Select --
Hepatitis	-- Select --
Epilepsy	-- Select --

Thyroid disorder	-- Select --
Do / Have you smoked?	-- Select --
Bleeding disorder	-- Select --
Arthritis	-- Select --
Sinus problems	-- Select --
Paget's or Sturge Weber	-- Select --

Recurrent headaches	-- Select --
Head or neck radiotherapy	-- Select --
Anaemia	-- Select --
Asthma	-- Select --
Ocular hypertension	-- Select --
Other medical issue	-- Select --

If you have answered YES to any of the above, please give details

_____

DENTAL HISTORY

What is the reason for your visit today? _____

How often do you have dental examinations / cleans? _____

How often do you brush / floss? _____

Would you like to have whiter teeth? -- Select --

Do you have any specific dental questions? _____

_____

How do you feel about dentists and dentistry?

(Comfortable) 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (Distressed)

CONSENT TO TREATMENT

- I authorise the dentist to take radiographs, study models, photographs and other diagnostics that are appropriate to make a full assessment of my dental needs.
- I authorise the dentist to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide appropriate care.
- I agree to the use of anaesthetics and other medication as necessary. I acknowledge that using anaesthetic agents embodies certain risks and understand that I can ask for a complete recital of possible complications.

YOUR COMMITMENT TO US

- I acknowledge that I will pay for my treatment in full at each appointment. We accept HICAPS, cash, cheques, EFTPOS, credit cards (MasterCard and Visa) or ***Denticare Payment Plans***
- I acknowledge that as a courtesy I will give you at least 2 business days' notice if I need to reschedule an appointment.

Check Form

Signed: _____

Date: _____

All details provided will be treated in the strictest confidence