NORTHMEAD
DENTAL

New Patient Form

Personal Details

Given Name: _____ Surname: _____ Title: _____

Date of Birth: ___/___/___ Phone: M_____ H_____ Email: _____

Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Medical Doctor: _____ Suburb: _____ Phone: _____

Do you have private health insurance that covers dentistry? ☐ No ☐ Yes > Name of fund: _____

How did you find out about us?

☐ Referred by existing patient or member of practice > whom may we thank for the referral? _____

☐ General Word of Mouth ☐ Work Locally ☐ Live Locally ☐ Google Search
☐ Facebook

Other > Please Specify _____

Medical History

We appreciate that you may wish to discuss some aspects of your medical history in private with your dentist. Should that be the case, please leave the form blank where appropriate.

Do you have any allergies?: ☐ Yes ☐ No
Are you allergic to: ☐ Latex ☐ Penicillin ☐ Other: _____

Please tick the corresponding box if you are being treated for, or if you have a history relating to any of the following conditions:

- ☐ Blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Cardiac pacemaker
- ☐ Hepatitis
- ☐ Sleep apnoea
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cancer/Tumours
- ☐ Radiation Therapy/Chemotherapy
- ☐ HIV/Aids virus
- ☐ Migraines / headaches
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Lung disease/Tuberculosis
- ☐ Artificial joints i.e. Hip, Knee
- ☐ Rheumatic fever
- ☐ Blood disorder
- ☐ Excessive bleeding
- ☐ Stomach/bowel disorder
- ☐ Mental health issue
- ☐ Eating disorder
- ☐ Osteoporosis
- ☐ Smoking
- ☐ Bisphosphonate Use
- ☐ Other > Please specify: _____

Have you had a recent illness or operation?: _____

Have you recently seen your doctor? ☐ No ☐ Yes > Please specify: _____
Ladies, are you currently pregnant? ☐ No ☐ Yes > What is your estimated due date?: _____

Are you presently taking any medications? ☐ No ☐ Yes > Please specify: _____

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Dental History and Conditions

Do you have concerns in the following areas?

- ☐ Receding gums/gum bleeding or disease
- ☐ Swelling, ulcers, lumps or cold sores
- ☐ Unpleasant breath
- ☐ Broken/chipped teeth
- ☐ Lost filling/crown
- ☐ Large fillings
- ☐ Discoloured teeth/fillings
- ☐ Unattractive smile
- ☐ Toothache
- ☐ Sensitivity to heat/cold or biting
- ☐ Missing teeth
- ☐ Wisdom teeth
- ☐ Dry mouth
- ☐ Sore or 'clicky' joint
- ☐ Facial pain
- ☐ Other: _____

When was your last dental visit? _____

How do you feel when you come to the dentist?

Not Anxious *Extreme Phobia*

Reason for anxiety: ☐ Bad experience ☐ Poor service in past ☐ Time ☐ Cost ☐ Nothing

Do you snore? ☐ No ☐ Yes > If you answered yes do you wake up unrefreshed or tired? ☐ No ☐ Yes
Do you grind your teeth? ☐ No ☐ Yes > If you answered yes do you wear a night guard? ☐ No ☐ Yes

Would you like information on straightening Teeth? ☐ No ☐ Yes
Would you like information on whitening teeth? ☐ No ☐ Yes

Northmead Dental Policy and Consent

Please select your preferred method of communication for appointment courtesy reminders:
☐ Email ☐ SMS ☐ Phone ☐ No reminders please

Cancellation Policy:

We understand that you may need to reschedule or cancel your appointment. We appreciate as much notice as possible but a minimum of 48 hours is requested. Unfortunately, if you do not notify us within this time or fail to attend an appointment, a fee of $50 per half hour of the appointment time will be charged.

Consent for Treatment:

I authorise the dentist or designated team member to take x-rays, study models, photographs and other diagnostic aids, agreed upon with myself, to make a thorough diagnosis. I authorise the dentist to perform treatment mutually agreed upon by me.
I agree to the use of local anaesthetic agents, sedatives and medications deemed necessary for my treatment following consultation with the dentist. I understand I can ask for a full list of any complications.
I agree to be responsible for all services rendered to myself or my dependents and understand that payment is due at the time the service is rendered.
I authorise that this data may be reviewed by team members of the dental practice.
I authorise the use of photographic material in promotional use for Northmead Dental.

Patient/Guardian's signature: _____ Date: _____

Dentist's signature: _____ Date: _____