

NEW PATIENT FORM

PATIENT INFORMATION			
Last Name:	First:	Birth date (dd/mm/yyyy):	
Preferred Name:			
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr <input type="checkbox"/> Miss <input type="checkbox"/> Master		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Home no.:	Mobile no.:	Work no.:	Occupation:
Address:			Postcode:
Email:		Health Fund Name:	
Family Doctor's Name:		Doctor's Phone Number:	
Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Full name of party responsible for fees if not the patient:			
Relationship to patient:		Phone number:	
We remind our patients of their appointments. Preferred method of contact:			
<input type="checkbox"/> SMS <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Mobile <input type="checkbox"/> Email			
How did you hear about us?		Referee Name:	
Other family members seen here:			

IN CASE OF EMERGENCY				
Name of local friend or relative:	Relationship to patient:	Home no.:	Mobile no.:	Work no.:

DENTAL PROFILE		
How long ago was your last visit to the dentist?		
Please tick any dental concerns you may have:		
<input type="checkbox"/> Toothache/Swelling <input type="checkbox"/> Sensitive Teeth <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Bad Breath	<input type="checkbox"/> Dry Mouth <input type="checkbox"/> Missing Teeth <input type="checkbox"/> Decay/Lost Filling <input type="checkbox"/> Broken/Worn Teeth <input type="checkbox"/> Denture Discomfort	<input type="checkbox"/> Rapidly Decaying Teeth <input type="checkbox"/> Grinding/Clenching <input type="checkbox"/> Face/Jaw Pain <input type="checkbox"/> Sleep Apnoea <input type="checkbox"/> Unhappy with Smile

MEDICAL HISTORY

How do you rate your general health?

Excellent
 Very Good
 Fair
 Poor

Please tick Yes or No and specify details for any Yes responses:

	Yes	No	Please elaborate
Heart Trouble/Heart Surgery/Cardiac Pace Maker/Stroke			
High or Low Blood Pressure			
Diabetes (or does anyone in the family?)			
Hepatitis, Liver Disease or Kidney Disease			
Rheumatic Fever			
Bronchitis, Asthma, or other chest condition			
Fainting attacks, giddiness, blackouts, epilepsy			
Arthritis			
Thyroid problem			
Osteoporosis, Bone or Joint Disease			
Bruising or persistent bleeding following injury, tooth extraction or surgery			
Sleep Apnoea			
AIDS, HIV or any other infectious diseases e.g. tuberculosis			
Radiation or Chemotherapy			
A bad reaction to general or local anaesthetic			
Treatment that required you to be in hospital			
Nervous or Anxiety Disorder			
Are you pregnant or is there a chance of you being pregnant?			
Do you smoke tobacco products now or in the past			
Are you aware of any allergies			
Current Conditions:			
Current Medications:			

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed up on by me, to be carried out by the dentists and their staff. I/personal nominated responsible assumes full financial responsibility for any treatment on the day.

Note: So that we can better cater to all of our valuable patients' needs, please be advised that Ballarat Family Dental operates a 24 hour rescheduling policy. Appointments rescheduled within less than 24 hour notice will incur a fee. For all appointments 1 hour or longer, we appreciate a courtesy 48 hour notice. Should you require further information regarding this policy, please ask our front office staff for details.

Patient/Guardian signature

Date