Ballarat Family Dental
ABN 28 732 928 262

# NEW PATIENT FORM

| | | | |
|---|---|---|---|
| Today's date (dd/mm/yyyy): | | | |
| **PATIENT INFORMATION** | | | |
| Last name: First: | | | Birth date (dd/mm/yyyy): |
| ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr ❑ Miss ❑ Master | | | Sex: ❑ M ❑ F |
| Home no.: | Mobile no.: | Work no.: | Occupation: |
| Address: | | | Postcode: |
| Email: | | | Private Health Insurance: |
| Family Doctor's Name: | | | Doctor's Phone Number: |
| Are you Aboriginal or Torres Strait Islander? ❑ Yes ❑ 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:<br>❑ SMS ❑ Home Phone ❑ Work Phone ❑ Mobile ❑ 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: | | |
| ❑ Toothache/Swelling<br>❑ Sensitive Teeth<br>❑ Bleeding Gums<br>❑ Loose Teeth<br>❑ Bad Breath | ❑ Dry Mouth<br>❑ Missing Teeth<br>❑ Decay/Lost Filling<br>❑ Broken/Worn Teeth<br>❑ Denture Discomfort | ❑ Rapidly Decaying Teeth<br>❑ Grinding/Clenching<br>❑ Face/Jaw Pain<br>❑ Sleep Apnoea<br>❑ 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 | Details |
|---|---|---|---|
| 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