



New Patient Form

(This information may affect your dental treatment and will be treated in strictest confidence)

Title: _____ **LAST NAME:** _____ **FIRST NAME:** _____
Date of Birth: ____/____/____
Address: _____ **Suburb** _____ **Postcode** _____
Telephone – Home: _____ **Work:** _____ **MOBILE:** _____
Occupation: _____
Email: _____

1. How would you rate your health? (Circle One) **Excellent Good Fair Poor**
2. Are you being treated by a doctor (GP) at present? **Yes No**

Doctor’s name, address and telephone number & reason(s):

3. Are you taking any medications or drugs at present (e.g. aspirin, contraceptive, etc)? **Yes No**

If yes, please list name(s) & reason(s):

4. Have you been in hospital in the past 12 months? **Yes No**

If yes, please list reason(s): _____

5. Have you ever had any kind of surgery? **Yes No**

If yes, please list type: _____

6. Are you a smoker? **Yes No**

If yes, are you interested in ceasing smoking? **Yes No**

7. (Females) Are you pregnant? **Yes No**

If yes, due date: ____/____/____

8. How would you rate your dental health? (Circle one) **Excellent Good Fair Poor**

9. How long is it since your last visit to the dentist? _____

10. Are you having any dental/mouth pain or discomfort at present? **Yes No**

11. Do your gums bleed when brushing your teeth? **Yes No**

12. Are you interested in whiter teeth? **Yes No**

13. Please mark any past or present illnesses (use the space below for additional details and other illnesses):

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Immunodeficiency	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Drug dependency	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Prostheses:	<input type="checkbox"/> Allergies:	<input type="checkbox"/> Cancer (specify)	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Rheumatic fever	- Pacemaker	- Latex (surgical rubber)	- Radiotherapy	- A
<input type="checkbox"/> Other congenital or acquired heart problem	- Heart Valve	- Drugs (eg penicillin)	- Chemotherapy	- B
<input type="checkbox"/> Heart disease	- Hip/Knee/Other Joint	<input type="checkbox"/> Asthma	<input type="checkbox"/> Head/neck injury	- C
<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Back problems	- Other
<input type="checkbox"/> Blood pressure high / low	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Respiratory (lungs) disease	<input type="checkbox"/> Osteoporosis or bone disorder	<input type="checkbox"/> Migraine
<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Endocrine disorders	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Recurrent herpes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Prolonged bleeding	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> CJD	<input type="checkbox"/> Blood disorders eg anaemia	<input type="checkbox"/> Fainting episodes
	<input type="checkbox"/> Hospital acquired infection (MRSA)		<input type="checkbox"/> Psychiatric Treatment	

Other: _____

14. Are you dentally covered by a health fund? **Yes No**

Health fund: _____

No. on card (i.e. 01, 1, 02): _____

Member ID: _____

I understand that my dental insurance carrier may pay less than the total bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents at each appointment.

My preferred payment method:

- Cash Debit Credit AmEx

Emergency Contact:

Name: _____

Home Tel: _____

Mobile: _____

How did you hear about us?

<input type="checkbox"/> Yellowpages – (Please Circle) Online / Print	<input type="checkbox"/> Health fund
<input type="checkbox"/> www.abc-dental.com.au	<input type="checkbox"/> Fitness First
<input type="checkbox"/> Referral by friends	<input type="checkbox"/> Other _____
-Name of friend: _____ (please specify)	
<input type="checkbox"/> Wentworth Courier	
<input type="checkbox"/> Shopping in Westfield	

If you work in Westfield please indicate shop name _____

Signed: _____ Date: _____

(Patient or parent / guardian)

If Parent/Guardian, Please Print First and Last Name: _____