

New Patient Form

Title Mr/Mrs/Miss/Dr

Patients Name **First** _____
Surname _____ **Birthdate** _____

Mailing Address _____ **P/Code** _____

Residential Address _____

Residential Phone _____ Please indicate on which phone number you would prefer to be contacted.

Work Phone _____

Mobile _____

Employers Name _____ **Phone** _____

Alternative Contact in Case of Emergency (not at your address)

Name _____ **Phone** _____

Name of Medical Doctor _____ **Phone** _____

Usual Dentist _____ **Time since last visit** months/years ___ / ___

How will you pay for today's visit? Cash/ Cheque/ Credit Card/ EFTPOS

Dental Insurance? Yes/No **Person responsible for fees** _____

Medical/Dental History

To be able to treat you properly the dentist needs your medical history.
Do you have, or have you ever had, any of the following? Please indicate with a tick, and elaborate where space permits.

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Murmur (Past/ Present) | <input type="checkbox"/> Stroke | <input type="checkbox"/> Eyesight impairment |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Blood Pressure (High/Low) | <input type="checkbox"/> Artificial Valves/ Joints
<small>If yes, do you need antibiotics before dental treatment?</small> | <input type="checkbox"/> Ulcers/gastric problems |
| <input type="checkbox"/> Malignancies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes/cold sores |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Chemotherapy
<small>If yes, for what?</small> | <input type="checkbox"/> Immune deficiency
<small>(eg Lupus, HIV)</small> | <input type="checkbox"/> Respiratory Problems
<small>(eg emphysema)</small> |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis If Yes -Type? | <input type="checkbox"/> Do you smoke? |

Ladies: Are you pregnant? Yes/No If yes how many weeks? _____

Please List all:

Medications <small>(prescribed + alternative/natural)</small>	Allergies <small>(past or present)</small>	Surgeries
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other conditions about which you feel the dentist should know.

Please tell us who referred you to us so we can thank them _____

Please explain the reason you are here today _____

Signature _____ **Today's Date** _____