



NEW PATIENT FORM

At Dental Clinique we strive to provide you with the highest possible care. To do this we need to collect personal information from you that include contact details and matters pertaining to your general health, both past and present. Without this information it is difficult for your dentist or hygienist to plan your care properly.

Please be assured that this information is maintained in accordance with State and Federal Privacy Legislation. If you would like any further information about how we use and protect your personal information, please ask one of our staff for our brochure "Personal Information, Privacy and your Dentist".

Surname:			Title:			Given Name:		
Preferred Name:				Date of Birth:				
Address:			Suburb:			Postcode:		
Home Phone:			Mobile:			Work:		
Email address:								
Vet Affairs Gold / White <small>please circle</small>			Vet Affairs Card Number:			Expiry Date:		
Name of Private Health Fund (if any)						Position No on card:		
Occupation:				Employer Name:				
Next of Kin								
Name:			Relationship			Phone:		
In case of an emergency whom should we contact? Please indicate if different to next of kin.								
Name:			Relationship:			Phone:		
Reminder System:								
<i>At Asquith Dental we remind our patients of their appointments. If you would like us to do this please indicate the preferred means of contact.</i>								
<input type="checkbox"/> SMS to Mobile <input type="checkbox"/> Call mobile <input type="checkbox"/> call home phone <input type="checkbox"/> call work phone <input type="checkbox"/> email								
How did you hear about us?								
<input type="checkbox"/> Referred by another patient <i>who?</i> _____ <input type="checkbox"/> Referred by staff <i>who?</i> _____								
<input type="checkbox"/> Yellow pages <input type="checkbox"/> Yellow pages online <input type="checkbox"/> Internet <input type="checkbox"/> Practice Website <input type="checkbox"/> Corporate Dental Program								
<input type="checkbox"/> DENTAL CARE NETWORK™ <input type="checkbox"/> New Patient Offer Card <input type="checkbox"/> Passing by?								
<input type="checkbox"/> Other: _____								

<p>Dental History</p> <p>How long is it since your last thorough dental examination?</p> <p> <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2years <input type="checkbox"/> 3 years <input type="checkbox"/> longer </p>					
<p>Please tick any dental concerns you have?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Toothache <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 </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Missing teeth <input type="checkbox"/> Unsatisfactory denture <input type="checkbox"/> Rapidly decaying teeth <input type="checkbox"/> Lost filling/cavity <input type="checkbox"/> Grinding/clenching teeth <input type="checkbox"/> Worn, broken teeth <input type="checkbox"/> Sick of ticking boxes? </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Pain in face or jaw joints <input type="checkbox"/> Sounds from joint <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Discoloured teeth <input type="checkbox"/> Bad appearance of teeth <input type="checkbox"/> Do you, or have you ever smoked? </td> </tr> </table>			<input type="checkbox"/> Toothache <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"/> Unsatisfactory denture <input type="checkbox"/> Rapidly decaying teeth <input type="checkbox"/> Lost filling/cavity <input type="checkbox"/> Grinding/clenching teeth <input type="checkbox"/> Worn, broken teeth <input type="checkbox"/> Sick of ticking boxes?	<input type="checkbox"/> Pain in face or jaw joints <input type="checkbox"/> Sounds from joint <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Discoloured teeth <input type="checkbox"/> Bad appearance of teeth <input type="checkbox"/> Do you, or have you ever smoked?
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<p>Medical History</p> <p>How do you rate your general health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Fair</p> <p>Who is your general practitioner? _____ Telephone: _____</p> <p><i>Have you had or are you suffering from any of these? (please tick)</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Heart Trouble / Surgery <input type="checkbox"/> Cardiac Pacemaker <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Arthritis <input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Epilepsy <input type="checkbox"/> Sleep Apnoea <input type="checkbox"/> Stroke <input type="checkbox"/> Stomach or digestive condition/reflux <input type="checkbox"/> Osteoporosis </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Nervous Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Liver or kidney disease <input type="checkbox"/> Are you or could you be pregnant <input type="checkbox"/> Excessive or prolonged bleeding <input type="checkbox"/> Radiation or chemotherapy <input type="checkbox"/> Eating disorder <input type="checkbox"/> Prosthetic implant/joint replacement <input type="checkbox"/> Organ or bone marrow transplant <input type="checkbox"/> Steroid therapy <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Do you smoke? </td> </tr> </table>			<input type="checkbox"/> Heart Trouble / Surgery <input type="checkbox"/> Cardiac Pacemaker <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Arthritis <input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Epilepsy <input type="checkbox"/> Sleep Apnoea <input type="checkbox"/> Stroke <input type="checkbox"/> Stomach or digestive condition/reflux <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Nervous Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Liver or kidney disease <input type="checkbox"/> Are you or could you be pregnant <input type="checkbox"/> Excessive or prolonged bleeding <input type="checkbox"/> Radiation or chemotherapy <input type="checkbox"/> Eating disorder <input type="checkbox"/> Prosthetic implant/joint replacement <input type="checkbox"/> Organ or bone marrow transplant <input type="checkbox"/> Steroid therapy <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Do you smoke?	
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<p>Are you allergic to anything eg local anaesthetic, latex, penicillin, peanut, etc (please specify)</p>					
<p>What medications including natural remedies are you taking?</p>					

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatment.

Patient signature: _____ Print Name: _____ Date: _____
(Parent or Guardian to sign if patient is a minor)

Checked by: _____ Print Name: _____ Date: _____