Deakin Dental

New Patient form

Date ___ / ___ / ___

About You

Title (Mr, Mrs etc.)

First name

Surname

Preferred name

Gender

Marital status

Birth date ___ / ___ / ___

Home address

Phone Number (H)

(M)

(W)

Email Address

Preferred contact ☐ Phone ☐ Email ☐ Text

Occupation

Employer

Dental Health fund ☐ Yes ☐ No

Details:

Previous Dentist

Last visit date

Other family seen by us? ☐ Yes ☐ No

How did you find out about us?

Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

First name

Surname

Relation

Phone Number (W)

(M)

Email Address

Confirmation

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorise the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Signature

Date ___ / ___ / ___

Internal use only

I verbally reviewed the medical/dental information above with the patient named herein.

Initals

Date ___ / ___ / ___

Comments

Unit 9
Deakin Sports Therapy Centre
Cnr Denison and King St
Deakin ACT 2600

02 6282 7711
hello@deakindental.com.au
deakindental.com.au

Thank you for your assistance in filling out this form. Answering the following questions allows your dentist to identify any problems that may affect your safety whilst visiting the practice.

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Dental History

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious/ difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Fresher breath? ☐ Yes ☐ No

How many times a week do you floss?

How many times a day do you brush?

Type of bristles: ☐ Hard ☐ Med ☐ Soft

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Your Health

Do you have a GP? ☐ Yes ☐ No

GP Name

Contact number

Date of last visit

Current health ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

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Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For women: Are you pregnant? ☐ Yes ☐ No (Weeks)

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or serious medical problems?

- ☐ Abnormal bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Anaemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Haemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Hospitalised for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

or other (please list)

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anaesthetics
- ☐ Erythromycin
- ☐ Jewellery
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

or other (please list)