Pacific Smiles Dental

New Patient Details Form

Title Dr / Mr / Mrs / Miss / Ms/ Other

Surname ______________________ First name ______________________ Date of birth ___/___/ _____

Preferred name ______________________ Your occupation ______________________

Home address ______________________

______________________ Postcode ______________________

Postal address ______________________ Postcode ______________________

Phone (Mob) ______________________ (Hm) ______________________ (Wk) ______________________

Email ______________________

Health fund for dental cover ______________________ Membership No. ______________________ Patient ID. ______________________

Medicare Card No. ______________________ Patient ID. ______________________ Vet Affairs Card No. ______________________

Emergency contact ______________________ Relationship to patient ______________________ Contact No. ______________________

Medical Practitioner ______________________ Contact No. ______________________

Person responsible for account (must be completed if patient under 16, if same as above please tick here ☐)

Name ______________________ Relationship to patient ______________________

Address ______________________ Postcode ______________________

Phone (Mob) ______________________ (Hm) ______________________ (Wk) ______________________

If third party, insurance company/employer responsible for account ______________________

Medical Questions – Private and Confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/Current medical conditions: (please circle)

Are you receiving any medical treatment at present? YES / NO Details ______________________

Have you had any serious or long standing illness? YES / NO Details ______________________

Have you ever been hospitalised? YES / NO Details ______________________

Are you currently pregnant or breastfeeding? YES / NO Due date if pregnant: ______________________

Do you or have you ever smoked? YES / NO How many per day? ______________________

Do you drink alcohol? YES / NO Amount per day or week? ______________________

Have you ever had or are you currently receiving treatment for cancer? YES / NO
Details ______________________

Are you allergic to any medications/tablets/antibiotics or other? YES / NO Details ______________________

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Current medications (prescription, over the counter, herbal) ______________________

____

New Patient Details Form

Please indicate if you have EVER had any of the following:

Any heart complaint / treatment	YES / NO	Tuberculosis	YES / NO
Rheumatic fever or heart valve surgery	YES / NO	Any nervous system disorder	YES / NO
High or low blood pressure	YES / NO	Gastric ulcer / digestive conditions	YES / NO
Blood disorders	YES / NO	Asthma / bronchitis / lung conditions	YES / NO
Anti-coagulant therapy	YES / NO	Radiation therapy / chemotherapy	YES / NO
Joint replacement surgery	YES / NO	Thyroid disease	YES / NO
Osteoporosis or bone disease	YES / NO	Hepatitis A,B or C	YES / NO
Epilepsy	YES / NO	Jaundice or other liver diseases	YES / NO
Diabetes	YES / NO	Transplanted organ or bone marrow	YES / NO
HIV or other blood borne viruses	YES / NO	Arthritis	YES / NO
Steroid therapy	YES / NO	Depression / anxiety	YES / NO
Sinus trouble	YES / NO	Kidney disease	YES / NO
Stroke	YES / NO	Bisphosphonate medications	YES / NO

Dental History – Private and Confidential

When was your last dental examination and clean? ______________________

Are you currently experiencing pain or a specific dental problem? YES / NO

Details ______________________

Are you nervous, anxious or ever had a bad experience at a dental visit? YES / NO

Details ______________________

Are you happy with the appearance of your teeth and smile? YES / NO

Details ______________________

Do you have bleeding gums or have you ever been diagnosed with or treated for gum disease? YES / NO

How frequently do you brush your teeth? ONCE A DAY / TWICE A DAY / Other ______________________

How frequently do you floss or use brushes to clean between your teeth? ______________________

Is there anything you would like to talk to your dentist about that you are not comfortable writing on this form? YES / NO

Would you like to discuss or find out more about any of the following: (please circle)

Replacement of missing teeth   Cosmetic appearance   Removal of wisdom teeth   Crowns   Veneers

Tooth whitening   Bad breath   Bleeding gums   Tooth grinding / Clenching   Root canal treatment

Replacement of silver (mercury) fillings   Dentures   Implants   Orthodontics

I agree that the above is a true and accurate record. I understand that this Pacific Smiles Dental centre requires payment on the day of treatment. Any expenses, costs or disbursements incurred by the Pacific Smiles Dental centre in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a non-refundable deposit requirement prior to future appointments being scheduled. I have read and agree with the privacy statement provided to me.

PLEASE NOTE: This form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

✗ Signature ______________________ Date ____ / ____ / ______