NEW PATIENT FORM

At Council Avenue Dental 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 please circle **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: *At Council Avenue Dental we remind our patients of their appointments. If you would like us to do this please indicate the preferred means of contact.* ☐ SMS to Mobile ☐ Call mobile ☐ call home phone ☐ call work phone ☐ email		
Email Updates: To be kept informed with updates on what is new in the practice, services and new dental techniques that may affect my next visit. ☐ No ☐ Yes		

How did you hear about us?

☐ Referred by another patient *who?* _____ ☐ Referred by staff *who?* _____

☐ Yellow pages ☐ Yellow pages online ☐ Internet ☐ Practice Website ☐ Corporate Dental Program
☐ DENTAL CARE NETWORK™ ☐ New Patient Offer Card ☐ Passing by?
☐ Other**:** _____

Dental History

How long is it since your last thorough dental examination?

☐ 6 months ☐ 1 year ☐ 2years ☐ 3 years ☐ longer

Please tick any dental concerns you have?

☐ Toothache	☐ Missing teeth	☐ Pain in face or jaw joints
☐ Sensitive teeth	☐ Unsatisfactory denture	☐ Sounds from joint
☐ Bleeding gums	☐ Rapidly decaying teeth	☐ Difficulty chewing
☐ Loose teeth	☐ Lost filling/cavity	☐ Discoloured teeth
☐ Bad breath	☐ Grinding/clenching teeth	☐ Bad appearance of teeth
☐ Dry mouth	☐ Worn, broken teeth	☐ Do you, or have you ever smoked?
	☐ Sick of ticking boxes?	

Medical History

How do you rate your general health? ☐ Excellent ☐ Good ☐ Poor ☐ Fair

Who is your general practitioner? _____ Telephone: _____

Have you had or are you suffering from any of these? (please tick)

☐ Heart Trouble / Surgery	☐ Nervous Disorders
☐ Cardiac Pacemaker	☐ Asthma
☐ High blood pressure	☐ HIV/AIDS
☐ Low blood pressure	☐ Liver or kidney disease
☐ Diabetes	☐ Are you or could you be pregnant
☐ Hepatitis	☐ Excessive of prolonged bleeding
☐ Rheumatic Fever	☐ Radiation or chemotherapy
☐ Arthritis	☐ Eating disorder
☐ Thyroid trouble	☐ Prosthetic implant/joint replacement
☐ Epilepsy	☐ Organ or bone marrow transplant
☐ Sleep Apnoea	☐ Steroid therapy
☐ Stroke	☐ Other (specify) _____
☐ Stomach or digestive condition/reflux	
☐ Osteoporosis	☐ Do you smoke?

Are you allergic to anything eg local anaesthetic, latex, penicillin, peanut, etc (please specify)

What medications including natural remedies are you taking?

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: _____