New patient
Medical and dental history

TDC
TEWANTIN DENTAL CENTRE

Part of Bupa

Date:

Patient details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other

Surname: Given name: D.O.B:

Residential address:

Suburb: State: Postcode:

Postal address (if different):

Home phone: Work phone: Mobile:

Email:

☐ We will send you email communications from time to time, including appointment reminders and our regular newsletter. Please tick this box if you don't wish to receive communication from us.

Occupation: Company:

Emergency contact: Phone: Relation:

Private health insurer: Member #: Patient #:

Medicare #: Ref #: Expiry: Vets Affairs #: Expiry:

GP name: GP phone:

GP address:

Preferred method of communication

☐ Email ☐ Letter ☐ SMS ☐ Telephone

Medical history

Please tick if you have ever had any of the following:

- ☐ Abnormal/excessive bleeding
- ☐ Angina
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Blood disorder (name below)
- ☐ Blood pressure (high/low)
- ☐ Blood thinner
- ☐ Bone disease (e.g. Osteoporosis)
  - ☐ Current or past Bisphosphonate therapy
- ☐ Cancer
- ☐ Cardiac surgery/pacemaker
- ☐ Congenital heart defect
- ☐ Diabetes type 1/type 2
- ☐ Epilepsy
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis A/B/C/D
- ☐ HIV positive
- ☐ Immune deficiency
- ☐ Kidney/liver disease
- ☐ Neurological disorder
- ☐ Oral ulceration
- ☐ Prosthetic joints
- ☐ Psychiatric care
- ☐ Radiation/chemotherapy
- ☐ Reflux
- ☐ Rheumatic fever
- ☐ Steroid therapy
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other condition (name below)

Medical history (continued)

Are you pregnant? ☐ Yes ☐ No If yes, how many months?

Are you Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Are you taking medication (including natural supplements)? If yes, please list:

Are you a smoker? ☐ Yes ☐ No If yes, how often?

Allergies

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs

☐ Other (please specify):

Dental history

Last dental visit: Is there a particular reason for your visit today?

Have you ever had a reaction or complication following dental treatment in the past? ☐ Yes ☐ No

If yes, please detail:

Is there anything else the dentist or hygienist should be aware of?

Do you generally feel anxious about seeing your dentist and/or hygienist?

☐ Yes - extremely ☐ Yes - very ☐ Yes - somewhat ☐ No - not at all

Are you suffering from any of the following?

☐ Bad appearance of teeth	☐ Discoloured teeth	☐ Lost filling/cavity	☐ Toothache
☐ Bad breath	☐ Dry mouth	☐ Rapidly decaying teeth	☐ Unsatisfactory denture
☐ Bleeding gums	☐ Grinding/clenching	☐ Pain in face/jaw	☐ Worn or broken teeth
☐ Difficulty chewing	☐ Missing teeth	☐ Sensitive teeth	
	☐ Loose teeth	☐ Sounds from joints	

Have you ever had a sleep study and been diagnosed with sleep apnoea? ☐ Yes ☐ No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? ☐ Yes ☐ No

Has anyone ever told you that you snore? ☐ Yes ☐ No

After 6-7 hours of sleep do you wake up refreshed? ☐ Yes ☐ No

How did you find out about us?

☐ Google ☐ Bupa store ☐ Bupa website ☐ TV advert ☐ Billboard advert

☐ Other (please specify): ☐ Referred by friend/family:

Privacy policy and signature

All personal information collected by Bupa Dental is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information. You can view the policy online at https://www.bupadental.com.au/privacy-policy.html.

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient/Legal guardian name: Signature: Date:

OFFICE USE ONLY.

Form checked by _____ Data keyed by _____ Keying checked by _____ Form scanned by _____