New patient form

Bupa Dental

Date:

Patient details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other:

Surname: Given name: D.O.B:

Residential address:

Suburb: State: Postcode:

Postal address (if different to above):

Home phone: Work phone: Mobile:

Email:

We communicate with our patients on a regular basis.

- If you do not wish to receive marketing communications from us such as our newsletter and offers, please tick this box: ☐
- If you do not wish to receive dental check-up reminders or any other form of appointment reminders from us, please tick this box: ☐

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 ☐ Phone

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
- ☐ Hearing impairment
- ☐ 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(s) (list below)

Medical history (continued)

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

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

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

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

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

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 ☐ Social Media ☐ Bupa store ☐ Bupa website ☐ Radio ☐ Print ad ☐ Billboard

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

Privacy policy and signature

Dental Corporation Pty Ltd (ABN 92 124 730 874) t/as Bupa Dental (Bupa Dental) collects personal information that is necessary for providing its services to you and to perform its business functions and activities. Bupa Dental may not be able to provide you with its products and services if you do not supply this information.

Bupa Dental may disclose your personal information to members of the Bupa Group, or to third parties engaged by us or acting on our behalf. We may also provide details to your health insurer if you choose to make a health insurance claim for your treatment. If you provide Bupa Dental with personal information about another person, it is your responsibility to inform them that you have done so and that they have a right to access their information.

All personal information collected by Bupa Dental is handled in accordance with our privacy policy, which can be viewed at https://www.bupadental.com.au/privacy-policy.html. This policy also contains information about accessing your information, requesting corrections to your information and how to make a complaint about the handling of your information.

*By signing this form you hereby agree and acknowledge that: **(i)** you have accurately completed this 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 dependants; **(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). This personal information will be handled in accordance with Bupa Dental's privacy policy.*

If you have any questions or concerns about how your personal information has been handled, please direct your correspondence to: The Privacy Officer, Bupa Dental Corporation, Level 15, 33 Exhibition Street, Melbourne, VIC, 3000 or email BD.PracticeStandards@bupa.com.au.

Patient/Legal guardian name:

Signature: Date:

Patient/Legal guardian phone/mobile:

OFFICE USE ONLY.

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