New patient
Medical and dental history

Patient details

Title: Mr Mrs Ms Miss Dr Other:

Surname: Given name: D.O.B:

Residential address:

Suburb: State: Postcode:

Postal address (if different):

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:

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 / Post Card SMS Telephone

Medical history

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

- Abnormal/excessive bleeding
- Angina
- Anxiety/depression
- 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
- Radiation/chemotherapy
- Reflux
- Rheumatic fever
- Steroid therapy
- Stroke
- Thyroid disorder
- Other condition(s) (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
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 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:

Patient/Legal guardian contact number:

OFFICE USE ONLY.

Form checked by ________ Data keyed by ________ Keying checked by ________ Form scanned by ________