Roslyn38
Exceptional Dentistry

New Patient History & Dental Form

We are pleased to welcome you to Roslyn 38.
Please complete the following confidential questionnaire as it will assist us in providing safe and accurate dental care.

Title_____ First Name_____ Surname_____

Address_____ DOB_____

Suburb_____ Post Code_____

Home Phone_____ Mobile Phone_____

E-mail_____ Occupation_____

Do you have private Health Insurance? Fund:_____ Veteran Affairs (If applicable) _____

Are you eligible for the Child Dental Benefit Schedule (CBDS)? □ Yes □ No
IF YES PLEASE FILL OUT MEDICARE DETAILS BELOW

Medicare Number: Ref #

Who Referred you to us?_____ Name of last Dentist_____

Emergency Contact Name_____ **Phone Number**_____

Medical Doctors Name_____ Phone (if known) _____

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes/No

Details_____

2. Have you taken any regular medications during the past two years or had any major surgery? Yes/No

Details_____

3. Have you experienced any allergies or unusual effects from any medications, injections or anaesthetic? Yes/No

Details_____

4. List any other medical conditions or allergies you may have_____

5. Have you ever had any of the following? If so, please tick as appropriate;

□ Rheumatic Fever	□ Arthritis	□ Diabetes-Type 1, Type 2
□ Heart Trouble-Please Specify	□ Hepatitis/HIV - Specify A,B,C	□ Anaemia
□ High Blood Pressure	□ Kidney Trouble	□ Epilepsy
□ Asthma	□ Thyroid Problems	□ Depressive Illness
□ Bronchitis, Chest Issues, TB-Specify	□ Gastric Problems	□ Severe Headaches
□ Stroke	□ Bone Disorders or Diseases	□ Cold Sores

6. Have you had any prosthetic surgery (e.g. Heart Valve or hip /knee replacement) Yes/No

Details_____

7. Women, are you pregnant? Yes/No If so, how many months? _____

8. Do you smoke? Yes/ No How many per day? _____ Do you drink alcohol? Yes/No How many per day? _____

DENTAL HISTORY

1. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes/No
2. Do you become anxious or uncomfortable when you are having dental treatment? Yes/No

PLEASE NOTE: PAYMENT IS REQUIRED ON THE DAY OF TREATMENT

I have completed this form to the best of my knowledge and understand that failure to make a full disclosure may place ME at undue medical risk, I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them In my treatment and I consent to this. I also give my permission for the practice to use the above details to send me appointment and check-up reminders. I agree that failing to give 24hrs notice for cancellation of appointments may incur a fee. I am aware that payment is required on the day of treatment; if collection services are required I agree to be responsible for all associated fees.

Signed: Patient/Parent/Gardian_____Date_____