elite dentistry

New Patient Form

Welcome to our Practice

Please answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Patient details

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ______

Surname: ______ Given name: ______ D.O.B: ______

Residential address: ______

Suburb: ______ State: ______ Postcode: ______

Postal address (if different): ______

Home phone: ______ Work phone: ______ Mobile: ______

Email: ______

Occupation: ______

Emergency contact: ______ Phone: ______ Relation: ______

GP name: ______ GP phone: ______

GP address: ______

Are you happy to receive emails, SMS or phone calls as notification of appointments or promotions?

☐ Yes ☐ No

To your knowledge have you now, or have you ever had

☐ Heart problems

☐ Herpes or shingles

☐ Diabetes

☐ Hepatitis

☐ Prolonged bleeding

☐ Healing problems

☐ Allergy to drugs

☐ Epilepsy

☐ Asthma or lung problems

☐ Allergy to jewellery

Are you or could you be pregnant? ☐ Yes ☐ No

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

______

Are you a smoker? ☐ Yes ☐ No

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Dental history

When was your last dental visit?: ____________________

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

If yes, please details: ____________________

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

If there was something you could change, what would it be?

____

Are your teeth sensitive to?

☐ Hot ☐ Cold ☐ Sweet ☐ Biting pressure

Are you aware of grinding your teeth at night or during the day? ☐ Yes ☐ No

Do your gums bleed when brushed? ☐ Yes ☐ No

How did you find out about us?

☐ Google/website ☐ Yellow pages ☐ Dental Care Network ☐ Radio ☐ Signage

☐ Other (please specify): ____________________

☐ Referred by friend/family: ____________________
(please give details)

On a scale of 1 – 10, with 10 being very comfortable and not at all anxious, how comfortable are you feeling about your appointment today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Privacy policy & signature

Any information is collected and maintained in accordance with State and Federal Privacy Legislation.
I have accurately completed this medical history form 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.
I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

I understand that my dentist may take images of my teeth both before and after my treatment.
I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.

Patient name: ____________ Signature: ____________ Date: ____________