

New Patient Information

Thank you for providing this information; it will be treated as confidential and private by all staff. We observe the Commonwealth Privacy Act 1988 and the NSW Health Records and Information Privacy Act 2002. For a copy of our Privacy Policy please ask for our brochure or consult our website.

Last name: _____ Mrs | Mr | Miss | Ms | Other _____ First name: _____

Other Names: _____ Preferred Name (if different to first name above): _____

Address: _____

_____ Post Code _____ Date of Birth _____

Home Phone _____ WorkPhone _____ Mobile _____

E-mail address _____

Preferred number: _____ Or, email? ☐

Contact person _____ Relationship _____

Their phone number? _____ Alternate number _____

Your medical GP _____ Address _____

Medical specialist(s) _____

Do you have any dental concerns or questions?

Fees

Our usual practice is to provide an accurate estimate of fees based on examination and consultation with you about your treatment. Any fee estimates given are valid for at least three months. You will receive an invoice when phases of treatment are complete and we request that you pay for treatment at each appointment when you receive an invoice. We accept cash, EFTPOS, Visa, Mastercard, and Amex. We operate a HICAPS terminal for on-the-spot claims from private health insurers.

Please complete the information on the other side of this form

Medical History-continued

Please circle if you now have or have had any of the following:

Angina

Heart Surgery

Valve replacement Bypass

Transplant

Atrial Fibrillation

Other cardiac/heart problems _____

Do you take Aspirin, Warfarin, or Apixaban [Eliquis], Rivaroxaban [Xarelto], Dabigatran [Pradaxa] Enoxaparin [Clexane]?

Any autoimmune diseases? _____

Blood or Bleeding Disorder _____

Diabetes _____ Kidney Disease _____

Sleep disordered breathing Sleep Apnoea Snoring Gastric Reflux: morning daytime evening

Hepatitis A B C Other hepatitis _____ Asthma Seizures of any type?

Do you smoke? If yes, how many per day and if you stopped—when? _____

Have you ever had pain, discomfort, irritation, ulceration on your tongue or other parts of your mouth? _____

Cancer – your

diagnosis: _____ When _____

Cancer treatment details: _____

Treatment for osteoporosis _____

Xerostomia (dry mouth)

Candidiasis (oral thrush)

Sjögrens Syndrome

Women – might you be pregnant? _____

Allergies/Adverse drug reactions e.g. Penicillin and/or other:

Name of drug taken	Description of allergy/reaction	How long ago?

Contact Hypersensitivity (e.g. metal jewellery, latex) _____

Medications: Please provide a full list of medications, both prescription and non-prescription and complementary medicines (vitamins, herbal remedies, fish oil etc.) that you take regularly or over the last year. If you have had any over-the-counter analgesics/pain relief in the past 24hrs please identify these as well. [PLEASE ASK FOR ANOTHER PAGE IF YOU RUN OUT OF SPACE]

NAME	DOSE	DURATION	REASON FOR USE

If there are areas of your care or medical history that you prefer to discuss in private (not use this form) please mark this box ☐

Signature _____ Date _____

Clinical photographs and x-rays: clinical photographs of teeth/gums and x-rays may be used for educational purposes and to communicate with specialists and other medical personnel; if used for education they will not identify you. If you DO NOT want them used please advise us.