

New Patient Form

Welcome to TC Smiles Dentalcare. To ensure that we give you the best service possible please complete the following:

Title:	First Name:	Surname:
Date of Birth:	Email Address:	
Residential Address:		
Suburb:	State:	Post Code:
Home phone:	Mobile:	Work phone:
Occupation:		Industry:

Emergency Contact:	Phone:	Relation:
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Do you have a health fund: Y / N If yes, which one:

Name of GP:	Name of Surgery:
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Have you had any of the following (please tick all that apply)?

- | | |
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| Abnormal Bleeding <input type="checkbox"/> | Joint Replacement <input type="checkbox"/> |
| Anaemia <input type="checkbox"/> | Jaundice <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> |
| Artificial Heart Valve <input type="checkbox"/> | Liver Disease <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Nervous Disorder <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Oral Cancer <input type="checkbox"/> |
| Blood Pressure High <input type="checkbox"/> Low <input type="checkbox"/> | Pregnant <input type="checkbox"/> Due date _____ |
| Cancer <input type="checkbox"/> | Psychological Disorders <input type="checkbox"/> |
| Cardiac Surgery <input type="checkbox"/> / Pace Maker <input type="checkbox"/> | Radiation Therapy <input type="checkbox"/> |
| Congenital Heart Defect <input type="checkbox"/> | Respiratory Problems <input type="checkbox"/> |
| Diabetes Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> | Rheumatic Heart Disease <input type="checkbox"/> |
| Epilepsy <input type="checkbox"/> | Sinus Problems <input type="checkbox"/> |
| Heart Murmur <input type="checkbox"/> / Attack <input type="checkbox"/> / Surgery <input type="checkbox"/> | Sleep issues <input type="checkbox"/> |
| Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| HIV <input type="checkbox"/> / AIDS <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> |
| | Warfarin Medication <input type="checkbox"/> |

How many cigarettes do you smoke per day? _____

How many units of alcohol do you consume a week? _____

Are you taking any medication?

Please List: _____

Do you have any allergies (drugs/food/material)?

Please List: _____

Is there anything else your Dentist or Hygienist should be aware of? _____

What is the main purpose of your visit today? _____

When and where was your last dental visit? _____

Have you ever had any of the following for dental treatment?

General Anaesthetic Intravenous Sedation Nitrous Oxide/Laughing Gas

Are you experiencing any of the following dental problems?

Sensitivity to hot or cold

Bad Breath

Discoloured teeth

Grinding / Clenching Teeth

Bleeding gums

Clicking / Pain in Jaw Joints

Food Trapping

Roughness of existing fillings

Snoring

Pain/Sensitivity when eating

Are you concerned with?

Your Smile

Ability to eat

Crooked teeth

Amalgam (silver) fillings

Missing teeth

Gaps between your teeth

Existing Crowns / Bridges / Dentures

Are you interested in?

Cosmetic Tooth Whitening

Clear Braces

Implants

Anti-wrinkle Injections

Lip Fillers

Sleep Devices

How did you hear about our practice?

Referred by existing patient

Whom can we thank: _____

Google

Signage

Facebook

Website

Health Fund

Other Please specify: _____

Consent for Treatment

I the undersigned, consent to the performance of dental and oral surgery procedures agreed to be advisable, including the use of local anaesthetics, and I will assume the responsibility for the fees associated with those procedures. I hereby consent to the use of study models, x-rays, computer images and photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

I am aware that full payment is required on the day of treatment and assume full financial responsibility. I understand the practice requires a minimum 24 hours cancellation notice, and a cancellation fee of \$50 may be incurred should this not occur. I understand that as a patient of TC Smiles I may receive information/marketing from TC Smiles in the form of Newsletter, email or sms. I understand that I will receive sms or email for confirmation of all dental appointments booked or missed overdue appointments I have accurately completed this preclinical examination questionnaire to the best of my knowledge. I hereby authorise the dentist to render any treatment agreed upon.

Patient signature: _____ Date: _____