New Patient Form

Welcome to Artarmon Dental Surgery! In order to provide you with the best possible treatment, we need to know about your state of health and medical history. All information will be treated in the strictest confidence. Please complete as accurately as possible.

Patient Information

Title

- (•) Mr
- ( ) Mrs
- ( ) Ms
- ( ) Mst
- ( ) Miss
- ( ) Dr
- ( ) Other

Name *

First | Last

Other Names

Address *

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Australia

Telephone: Home

Telephone: Work

Telephone: Mobile *

Email *

Health Fund

Name of Emergency Contact Person *

First Last

Relationship to Patient *

Phone of Emergency Contact Person *

How did you find out about us?

If referred, by whom?

What is your occupation (optional)?

Person responsible for account

☐ If the same person as above, please tick here

Name

First | Last

Relationship to Patient

Address

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Australia

Telephone: Home

Telephone: Work

Telephone: Mobile *

Past and Present Medical Conditions

Anaemia

◉ Yes ○ No

Arthritis

◉ Yes ○ No

Artificial Joints

◉ Yes ○ No

Asthma

◉ Yes ○ No

Bleeding Disorder

◉ Yes ○ No

Blood Transfusion

◉ Yes ○ No

Bone Density Test

◉ Yes ○ No

Cancer

◉ Yes ○ No

Chemotherapy / Radiotherapy

◉ Yes ○ No

Cholesterol (High / Low)

◉ Yes ○ No

Diabetes

◉ Yes ○ No

Epilepsy

◉ Yes ○ No

Gastrointestinal Disorder

◉ Yes ○ No

Hepatitis (A, B, C, D)

◉ Yes ○ No

Crohn's Disease

◉ Yes ○ No

HIV / AIDS

◉ Yes ○ No

Heart Conditions - Pace maker?

◉ Yes ○ No

Hypertension (High Blood Pressure)

◉ Yes ○ No

Hypotension (High Blood Pressure)

◉ Yes ○ No

Kidney Disorder

◉ Yes ○ No

Liver Disorder

◉ Yes ○ No

Lung Disorder

◉ Yes ○ No

Physically Disable

◉ Yes ○ No

Rheumatic Disorder

◉ Yes ○ No

Smoker

◉ Yes ○ No

Smoker

◉ Yes ○ No

Thyroid Disorder

◉ Yes ○ No

Tuberculosis

◉ Yes ○ No

Osteoporosis

◉ Yes ○ No

Reflux

◉ Yes ○ No

***Specify (if yes)**

Current Medication (Prescriptions, OTC, Herbal)

Do you have any heart condition (previous or current)?

Allergies: Nil Known / Yes (specify if yes)

Previous hospitalization / Surgery: Nil Known / Yes (specify if yes)

Other relevant details:

Medical Practitioner

First Last

Phone number of Medical Practitioner

Have you had any form of cancer?

Women only - Are you currently pregnant or breastfeeding?

Dental History

What is your main reason for attendance today?

When was your last dental visit?

When did you last have dental xrays?

Years

Months

Did you ever experience any of the following?

Jaw Pain

☐ Yes ☐ No

Sensitivity to hot or cold

☐ Yes ☐ No

Bad Breath

☐ Yes ☐ No

Would you like a reminder for you 6 monthly check-up?

☐ Yes ☐ No

If yes, would you prefer via Post or SMS

☐ Post ☐ SMS