Conder Medical & Dental Centre

New Dental Patient Form

Title (please circle): Mr Mrs Miss Other

Given Names: ..... **Surname:** .....

Preferred Name: ..... **D.O.B.** .....

Address: .....

Suburb: ..... **Postcode:** .....

Home Phone: ..... **Mobile:** ..... **Work:** .....

Email address: .....

Private health fund (if any): .....

Occupation: .....

Employer: .....

Next of Kin

Name: ..... **Relationship:** ..... **Phone:** .....

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT? (If different to next of kin)

Name: ..... **Relationship:** ..... **Phone:** .....

Dental History

How long has it been since your last dental examination?

6 months ☐ **1 year** ☐ **2 years** ☐ **3 years** ☐ **longer** ☐

Medical History

Who is your General Practitioner? ..... **Phone:** .....

How do you rate your overall health?

Excellent ☐ **Good** ☐ **Poor** ☐ **Fair** ☐

Do you smoke? **Yes** ☐ **No** ☐ **If yes, how many per day?** .....

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Have you had or are you currently suffering from any of the following?

Heart Conditions/Surgery	☐	Stroke	☐
Cardiac Pacemaker	☐	Digestive condition/reflux	☐
High Blood Pressure	☐	HIV/AIDS	☐
Low Blood Pressure	☐	Liver or Kidney Disease	☐
Diabetes	☐	Are you/could you be pregnant	☐
Hepatitis	☐	Excessive or prolonged bleeding	☐
Rheumatic Fever	☐	Radiation & Chemotherapy	☐
Arthritis	☐	Eating Disorder	☐
Thyroid Issues	☐	Prosthetic implant/joint replacement	☐
Epilepsy	☐	Organ or marrow transplant	☐
Sleep Apnoea	☐	Other (specify).....	
Steroid Therapy	☐	.....	
Osteoporosis	☐		

Does dental treatment make you nervous?

Yes ☐ No ☐ Moderately ☐ Extremely ☐

Have you ever required the use of the following for dental treatment?

Nitrous Oxide ☐ Intravenous ☐ Sedation ☐ General Anaesthesia ☐

Are you allergic to anything? E.g. local anaesthetic, latex, penicillin, etc. Yes ☐ No ☐

If yes please specify: .....

What medications are you currently taking? (Including natural remedies)

Have you been in hospital recently? Yes ☐ No ☐

If yes, what for? .....

(I have completed the pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed on by me, to be carried out by the dentist and their staff and I assume full financial responsibility for said treatment)

Patient Signature: ..... **Print Name:** ..... **Date:** .....

(Parent or guardians signature if the patient is under the age of 18)

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