New patient
Medical and dental history

Claremont FAMILY DENTAL
247 Stirling Highway
Claremont, WA 6010
9 286 3701

Date:

Patient details

Title: ☐ Mr ☐ Mrs ☐ 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: Company:

Emergency contact: Phone: Relation:

Private health insurer: Member #: Patient #:

Vets Affairs #: Expiry:

GP name: GP phone:

GP address:

Preferred method of communication

☐ Email ☐ Letter ☐ SMS ☐ Telephone

☐ We will send you email communications from time to time, including appointment reminders and our regular newsletter. Please tick this box if you don't wish to receive communication from us.

Medical history

Please tick if you have ever had any of the following:

- ☐ Abnormal/excessive bleeding
- ☐ Angina
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Blood disorder (name below)
- ☐ Blood pressure (high/low)
- ☐ Blood thinner
- ☐ Bone disease (e.g. Osteoporosis)
  - ☐ Current or past Bisphosphonate therapy
- ☐ Cancer
- ☐ Cardiac surgery/pacemaker
- ☐ Congenital heart defect
- ☐ Diabetes type 1/type 2
- ☐ Epilepsy
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis A/B/C/D
- ☐ HIV positive
- ☐ Immune deficiency
- ☐ Kidney/liver disease
- ☐ Neurological disorder
- ☐ Oral ulceration
- ☐ Prosthetic joints
- ☐ Psychiatric care
- ☐ Radiation/chemotherapy
- ☐ Reflux
- ☐ Rheumatic fever
- ☐ Steroid therapy
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other condition (name below)

Medical history (continued)

Are you pregnant? ☐ Yes ☐ No If yes, how many months?

Are you Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

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

Are you a smoker? ☐ Yes ☐ No If yes, how often?

Allergies

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs

☐ Other (please specify):

Dental history

Last dental visit: Is there a particular reason for your planned visit?

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

If yes, please detail:

Is there anything else the dentist or hygienist should be aware of?

Do you generally feel anxious about seeing your dentist and/or hygienist? ☐ Yes ☐ No ☐ Sometimes

Are you suffering from any of the following?

- ☐ Bad appearance of teeth
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Difficulty chewing
- ☐ Discoloured teeth
- ☐ Dry mouth
- ☐ Grinding/clenching
- ☐ Missing teeth
- ☐ Loose teeth
- ☐ Lost filling/cavity
- ☐ Rapidly decaying teeth
- ☐ Pain in face/jaw
- ☐ Sensitive teeth
- ☐ Sounds from joint
- ☐ Toothache
- ☐ Unsatisfactory denture
- ☐ Worn or broken teeth

Have you ever had a sleep study and been diagnosed with sleep apnoea? ☐ Yes ☐ No

Has anyone ever told you that you snore? ☐ Yes ☐ No

How did you find out about us?

☐ Google ☐ Bupa store ☐ Bupa website ☐ Referred by Doctor or Specialist ☐ Location

☐ Referred by friend/family: ☐ Other (please specify):

Privacy policy and signature

All personal information collected by Claremont Family Dental is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information. You can view the policy online at our practice website or http://www.dentalcorp.com.au/Contact-Us-Australian-Privacy-Policy-GBL.

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient/Legal guardian name: Signature: Date:

OFFICE USE ONLY.

Form checked by _____ Data keyed by _____ Keying checked by _____ Form scanned by _____