NEW PATIENT FORM

Please take your time to answer these questions as completely as possible. It will assist us in our efforts to provide the best dental treatment for you.

Lower Templestowe Dental Excellence

CONFIDENTIAL MEMBER INFORMATION

Mr | Ms | Mrs | Dr | Miss | Master | Mx

Surname _____ Given Name/s _____

Preferred Name _____ Date of birth _____

Address _____

Mobile _____ Home/Work _____ Email _____

Occupation _____ Employer _____

Private Health Insurance Fund _____ Card Number _____

Emergency Contact _____ Emergency Number _____

Who is your Doctor/General Practitioner? _____

Can we thank anybody for referring you to us? _____

We may occasionally send you email communications including appointment reminders, our newsletter and offers for our existing clients. ☐ *Please tick this box if you do not wish to receive communications from us.*

MEDICAL HISTORY

Have you ever experienced:

	Present	Past	Never		Present	Past	Never
High/Lower Blood Pressure				Anaemia			
Rheumatic Fever				Radiation Therapy			
Angina				Chemotherapy			
Heart Murmur				Asthma			
Hepatitis				Tuberculosis			
Epilepsy				Diabetes (1 or 2)			
Endocarditis				Kidney Disease			
Stroke				Excessive Bleeding			

Do you have any other serious illness? _____

_____

_____

	(Please tick one) Yes	No
Do you consider yourself to be in a high-risk HIV category?		
Artificial joint replacements, heart valve or prosthetic implants? Please list details:		
Have you had any past problems with dental treatment?		
Are you currently taking any medication? (natural or recreational) Please list:		
Are you allergic to Penicillin?		
Are you allergic to Latex?		
Are you allergic to any other drugs or medicine? Please list:		
Have you had Cortisone in the past 12 months?		
Have you had Botulinum Toxin or Dermal Fillers in the past 12 months?		
Are you breast feeding OR is there a possibility that you are pregnant?		
Are you a smoker? Y / N Average number smoked per day:		

Lower Templestowe Dental Excellence

PREVENTATIVE CONSULTATION

To help formulate an individual program, we need to ask a few questions about your dental history and oral hygiene routine.

When was your last dental examination?

When were your last dental x-rays? *Inside the mouth:* *Outside the mouth:*

When was your last professional clean? *Dentist:* *Hygienist:*

To prevent dental decay and gum disease, we recommend scheduling a recall appointment every 3-6 months. Dental x-rays are taken every 12-24 months, allowing us to examine between the teeth and gums. This allows us to work with you to achieve optimum oral health.

	Yes	No
Are you experiencing any dental pain or discomfort? *Please tick applicable:*		
Sharp Pain ☐ Constant Ache ☐ Throbbing ☐ Intermittent Pain ☐ Unprovoked Pain ☐		
Do you experience any pain when biting or chewing?		
Are your teeth sensitive to hot/cold or sweetness?		

When did the sensitivity begin? _____

FRESH BREATH AND DRY MOUTH

	Yes	No
Do you have a dry mouth during the day?		
Do you suffer from bad breath?		
Has anyone ever mentioned you have bad breath?		
Do you suffer from frequent sinus problems?		

GUM HEALTH

	Yes	No
When you brush or floss, do your gums bleed?		
Do you find food gets caught between your teeth easily?		
Does your family have history of gum disease?		
Has anyone ever told you that you grind or clench your teeth? (Night or day)		
Have you ever had any problems associated with previous dental treatments?		
Please explain:		

How can we make your dental appointment more comfortable? _____

_____

ORAL HYGIENE ROUTINE

What sort of toothbrush do you use? Manual ☐ Electric ☐
How often do you brush?
Type of toothbrush bristles? Soft ☐ Medium ☐ Hard ☐ Unsure ☐
What toothpaste do you use?
How often do you floss?
Do you use mouthwash? Yes ☐ No ☐ If so, what type? _____
What level of refined sugars are in your regular diet? Low ☐ Medium ☐ High ☐
How often do you drink coffee or tea? _____ With sugar ☐ Without sugar ☐
Have you noticed your teeth are not as white as they used to be? Yes ☐ No ☐
Would you like to change anything about your smile? _____

_____

_____

Please turn to the next page

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PRIVACY CONSENT FORM

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment & information to you. Personal information such as your name, email/address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services, current health updates and any issues affecting your treatment.
2. We may disclose your health information to other health care professionals, or require it form them if, in our judgement, that is necessary in the context of your treatment in that event, disclosure of your personal details will be minimised wherever possible.
3. We may also use parts of your health information for research purposes, in study groups or seminars as this may provide benefit to other patients. Should this happen, your personal identity will not be disclosed to do so.
4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

SIGNATURE

☐ Ticking this box certifies that:

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk.

I agree that once my appointment is confirmed, I will endeavour to let Lower Templestowe Dental Excellence know at least 24hours before the appointment time of any changes, otherwise I may incur a late cancellation fee.

I understand that it is the policy of the practice that all payments should be made at the time of the consultation unless alternative arrangements have been made.

Full Name (Printed) _____

Signature _____ Date _____