WiSE DENTAL

NEW PATIENT FORM

Title: Given Name: Surname:
Preferred Name: D.O.B:
Address:
Suburb: Postcode:
Home Phone: Work Phone:
Mobile: Email Address:
Name of Private Health Fund (if any):
Occupation: Employer name:
In case of an emergency, who should we contact? Name: _____ Relationship: Phone Number/s:
we remind our patients of their appointments. Please indicate your preferred means of contact. ʻed means of contact. ❑ Home Phone ❑ Work Phone ❑ Mobile
In the future, we hope to expand your options for receiving your appointment reminders. When these options are accessible to us, how would you prefer we contact you? Please number in order of preference if choosing more than 1 option. ❑ Home Phone ❑ Work Phone ❑ Mobile ❑ Twitter ❑ Email ❑ SMS to Mobile ❑ Facebook ❑ Other: _____
Would you like to be kept informed via email with updates on what is new in the practice, services and new dental techniques that may affect your next visit? ❑ Yes ❑ No
All accounts are to be settled at the end of each appointment. If a carer / guardian / parent is responsible for settling the account, please give details: Name: Relationship:
Address (if different from above):
Suburb: Postcode:
Home Phone: Work Phone:
Mobile:
Who can we thank for recommending you to us? ❑ Practice Website ❑ Yellow Pages ❑ Yellow Pages Online ❑ Local Directories ❑ Location ❑ Internet ❑ Friend / Family (who): _____ ❑ Other (please specify): _____

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WiSE DENTAL

NEW PATIENT FORM (continued)

How long is it since your last dental examination?

❑ 6 months ❑ 1 year ❑ 2 years ❑ 3 years ❑ longer

Please tick any dental concerns you have.

❑ Toothache	❑ Unsatisfactory denture	❑ Bad breath
❑ Sensitive teeth	❑ Rapidly decaying teeth	❑ Loose teeth
❑ Bleeding gums	❑ Pain in face or jaw joints	❑ Worn teeth
❑ Grinding / clenching teeth	❑ Sounds from joint	❑ Dry mouth
❑ Bad appearance of teeth	❑ Discoloured teeth	❑ Missing teeth

How do you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you smoke? ❑ Yes ❑ No

Who is your general practitioner? Name: _____ Phone: _____

Have you had, or are you suffering any of the below?

❑ Heart Condition	❑ HIV infection	❑ High Blood Pressure
❑ Rheumatic fever	❑ Excessive bleeding	❑ Diabetes
❑ Artificial joint	❑ Osteporosis	❑ Stroke
❑ Hepatitis	❑ Thyroid problems	❑ Asthma
❑ Infectious diseases*	❑ Cancer	❑ Epilepsy
*eg/ CJD, TB, Staph, etc	❑ Radiation or Chemotherapy	❑ Sleep Apnoea

If yes to any of the above, please specify details: _____

If you have indicated a heart complaint above, please tick those that apply:

❑ Heart attack	❑ Angina	❑ Surgery	❑ Bypass
❑ Pacemaker	❑ Murmur	❑ Valve problem	

Are you taking any of these medications?

❑ Warfarin (Coomadin / Marevan)

❑ Aspirin (Astrix / Cartia)

❑ Plavix (Iscover)

Are you taking any biphosphanate medications, or medications for osteoporosis, multiple myeloma, metastatic cancer or pagets disease? ❑ Yes ❑ No

(If yes, please specify): _____

What medications, including natural remedies are you taking?

(Please specify): _____

Are you allergic to anything? eg/ local anaesthetic, latex, penicillin, peanut etc

(Please specify): _____

Is there anything else about your health you believe we should know?

(Please specify): _____

Patient signature: _____ (parent or guardian to sign if patient is a minor)

Print name: _____ Date: _____

Checked by*: _____ Print Name: _____ Date: _____

(*staff member signature