Newington Dental Care

1 PATIENT INFORMATION

Title	Dr./ Mr./ Mrs./Ms./Miss		
Surname		Given Name/s	
Preferred Name		Date of Birth	
Languages spoken			

Address	
Suburb/Postcode	
Home Phone	
Work Phone	
Mobile Phone	
Email Address	

Please place asterisk * for preferred contact number

Occupation and Employer	
General Practitioner	
Referred by/How did you find out about us?	☐ Personal Reference If so by who:_____ ☐ Online Yellow Pages ☐ Walk In ☐ GP Referral ☐ Internet Search ☐ Other:_____
Do you have dental cover? If so, please name health fund	Yes/No
Membership number/Family number	( )

2 DENTAL HISTORY

Reason for today's visit	
How long since your last dental visit?	
How long since your last dental x-rays?	
Do you smoke?	Yes/No
Do you play contact sports? If so, do you use a mouthguard?	Yes/ No Yes/ No

FORM CONTINUES OVERLEAF >>>

3 MEDICAL HISTORY

Medications currently taken:
Allergies (especially to antibiotics, medications and latex):
Recent Hospitalisation:
(Women) Are you pregnant? Yes/No If so, what trimester? Are you taking the contraceptive pill? Yes/No

Tick if you have/had any of the following:

Heart issues:		Do you have any bone conditions?	
Artificial Valve		Osteoporosis	
Congenital Defect		Cancer spread to bones	
Murmur		Artificial joint replacement	
Pacemaker		Other:	
Cardiac Surgery			
Rheumatic fever			
Prolonged bleeding/bleeding disorder Please specify:		Previously or currently taking any Bisphosphonate medications? e.g. Fosamax (please enquire if you are unsure)	
High blood pressure		Epilepsy	
Liver disease/disorder		Recreational drugs	
Kidney disease/disorder		HIV /AIDS	
Stomach or gastro-intestinal tract		Hepatitis, if so circle A/B/C	
Stroke		Cancer	
Diabetes		Chemotherapy	
Asthma		Radiotherapy	
Thyroid disorder		Immune-suppressed state	
Do you have any condition, disease or problem not listed above? Please specify:			

4 TERMS & CONDITIONS

In signing you consent to the performance of diagnostic services and dental treatment for the above patient by the staff of Newington Dental Care, and the information provided above are accurate to your knowledge. You also acknowledge that payment is required at the time of service, on the day of treatment. Appointment times are reserved for you; a minimum 24 hours notice is required for cancellations to avoid a failure to attend charge.

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Patient/ Guardian Signature Date