The Happy Tooth
Kurri Kurri

New Patient & Dental History Form

We are pleased to welcome you to our practice. Please complete the form. The following information is necessary to enable us to provide you with your best dental care. All information disclosed is confidential.

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PERSONAL DETAILS

Please Circle (Mr, Mrs, Ms, Miss, Mst) Age _____ DOB _____

First Name _____ Middle Name _____ Surname _____

Address _____

Suburb _____ Post Code _____

Phone (Home) _____(Work)_____ Phone (Mobile) _____

Email Address _____

Occupation _____ Company _____

Emergency Contact Name:_____Phone:_____

GP's Name and Location _____

Health Fund Name _____

If you are under 16, please name your parents/guardians _____

How did you find out about us? _____

HEALTH DETAILS

Do you have, or have you ever had any of the following conditions?

PLEASE LIST DETAILS OF CONDITION

Yes	No		
☐	☐	Allergies (eg. Penicillin, sulphur, codeine, latex)	(PLEASE SPECIFY)
☐	☐	Arthritis	
☐	☐	Artificial Joints (eg. Hip or knee replacement)	
☐	☐	Bone Disorders (eg. Osteoporosis, Pagets disease, cancer of bone)	
☐	☐	Cancer or tumour	
☐	☐	Diabetes	
☐	☐	Epilepsy or other Neurological Disorder	
☐	☐	Fainting or dizziness	
☐	☐	Hepatitis B or C	
☐	☐	HIV/AIDS	
☐	☐	Heart Problems (eg. Heart attack, angina, stroke, murmur)	
☐	☐	Heart Surgery (eg. By-pass, valve replacement, pacemaker)	
☐	☐	High or low blood pressure (please specify)	
☐	☐	Kidney or liver disease	
☐	☐	Mental health issues	
☐	☐	Radiation treatment to head or neck	
☐	☐	Respiratory problems	
☐	☐	Sinus problems	
☐	☐	Have you ever taken a bisphosphonate? (eg. actonel, zometa, fosamax etc.)	
☐	☐	Do you bruise or bleed easily after injury?	
☐	☐	Do you smoke or use other forms of tobacco?	
☐	☐	Are you, or suspect you may be pregnant?	

List all current medication _____

_____

Is there anything else you can tell us about your general health?_____

Please Turn Over

YOUR DENTAL HISTORY

What is the reason you have come to see me today? ----------

How long is it since you have seen a dentist? ----------

How long has it been since you have had dental x-rays? ----------

Yes	No	
☐	☐	Does food catch regularly in particular places between your teeth?
☐	☐	Do your gums bleed when brushing?
☐	☐	Are any of your teeth loose?
☐	☐	Are any of your teeth sensitive to hot, cold, pressure or tooth brushing?
☐	☐	Are you aware of grinding or clenching your teeth?
☐	☐	Do you have clicking or pain in the jaw joints?
☐	☐	Do you snore or have sleep apnoea?
☐	☐	Is there anything you dislike about the appearance or colour of your teeth?
☐	☐	Have you ever seen a Dental Specialist? (eg. Periodontist, Endodonist)
☐	☐	Have you had your wisdom teeth removed?
☐	☐	Have you ever seen or plan to see an orthodontist? Please tick

Please tick below which oral hygiene aids you use

☐ Toothbrush ☐ Electric Toothbrush ☐ Dental Floss

☐ Interdental Brushes ☐ Mouthwash ☐ Other ----------

How do you feel about having dental treatment at this surgery today? Please tick

☐ Extremely Nervous ☐ Moderately Nervous

☐ Mild case of nerves ☐ Relaxed and Confident

Yes	No	Do you want your treatment at this surgery to involve:
☐	☐	Examination of your teeth and mouth
☐	☐	Relief of pain today only, no further treatment today
☐	☐	Repair of teeth as required
☐	☐	Regular follow up, cleaning and preventative services
☐	☐	Consultation with you as to your treatment needs

What are your greatest concerns and needs for your dental treatment? ----------

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CONSENT AND ACKNOWLEDGEMENT

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with these procedures.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee may apply.
- I understand that if I fail to attend a fee may apply.
- I am aware that payment is required on the day of treatment.
- I consent to my email address being used for treatment and health promotional materials.

We provide a courtesy to our patients a preventative recall program that offers a call service if you have not been to the practice in 6 months.

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Patient/Guardian Signature Date of Signature