New Patient Form

Title: Mr Mrs Ms Miss Date of birth: / /

First Name: _____Last Name: _____

Address: _____ postcode:

Home #: _____ Work #: _____Mobile #: _____

Email:_____

Sex: Male / Female

How did you first hear about us?

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?

Insurance Information

Do you have Dental insurance? Yes No

Health fund:

Membership No:

Person Responsible for Account

Name:

Relationship to patient (Circle): Self Spouse Parent Other:

Phone No:

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone / Text / Email

In the event of an emergency, whom should we contact?

Name:

Phone no:

Medical History

1. Are you receiving any medical treatment at present? Yes No

If yes, what for?_____

2.Have you ever had any excessive bleeding requiring special treatment? Yes No

3.are you taking blood thinners or anticoagulants? Yes No

4.have you ever had Rheumatic fever? Yes No

5.Ever had any type of heart (Cardiac)complaint/ treatment? Yes No

6.do you have heart murmur or a pacemaker? Yes No

7. do you faint easily? Yes No

8.do you have Diabetes? Type1 Type 2 Yes No

9.do you have Osteoporosis or other bone related conditions?
Yes No

10.do you have or ever tested positive to AIDS/HIV/TB? Yes No

11.do you suffer from Epilepsy, convulsions or seizures? Yes No

12. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

If pregnant due date:

13. Are you allergic to or have you had an allergic reaction to any medication or substance? Yes No

If yes what substance_____

14.Do you smoke? If yes how much per day? Yes No

15. Please list all medications you are taking:

_____

Dental History

1. When was your last dental checkup?

2-when were your last dental x-rays?

3-How would you describe your dental health? Excellent Good Fair Poor

4- what do you use to clean your teeth? Brush Floss Mouth rinse Piksters

5- what type of toothbrush do you use? Hard Medium Soft

6. Are you having tooth or gum pain at this time? Yes No

7. Do you feel nervous about having dental treatment? Yes No

8. Have you ever had a bad experience in a dental office? Yes No

9. Do your gums bleed when brushing / flossing? Yes No

10. Have you ever seen a periodontist? Yes No

11.Are your teeth sensitive to hot or cold? Yes No

12. Have you ever had Orthodontic Treatment (Braces)? Yes No

13. Would you be interested in discussing ways to improve your smile? Yes No

Do you have any of the following dental concerns?

Clicking in jaw joint Biting	Yes No	Sensitivity to:	Hot	Cold	Sweets
Pain in or around your ears	Yes No	Swelling		Bleeding Gums	
Difficulty opening or closing	Yes No	Bad Taste		Bad Breath	
Difficulty chewing	Yes No	Food Catching		Tooth Pain	
History of trauma to jaw or face	Yes No	Clenching		Grinding	
Diagnosis of TMJ/TMD	Yes No	Other:			

Cosmetic Evaluation:

1- Are you happy with your smile?

2- would you like information on teeth whitening?

3-Does replacing your existing Amalgam fillings interest you ?

4-Would you like straighter teeth?

What is the purpose of your visit?

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____

Date_____