

New patient

Medical and dental history



Silas Street Dental

Date:

Patient details

Title: Mr Mrs Ms Dr Other:

Surname: Given name: D.O.B:

Residential address:

Suburb: State: Postcode:

Postal address (if different):

Home phone: Work phone: Mobile:

Email:

We will send you email communications from time to time, including our regular newsletter and offers.
Please tick this box if you don't wish to receive communication from us.

Occupation: Company:

Emergency contact: Phone: Relation:

Private health insurer: Member #: Patient #:

Medicare #: Ref #: Expiry: Vets Affairs #: Expiry:

GP name: GP phone:

GP address:

Preferred method of communication

Email Letter SMS Telephone

Medical history

Please tick if you have ever had any of the following:

Abnormal/excessive bleeding	Cardiac surgery/pacemaker	Oral ulceration
Angina	Congenital heart defect	Prosthetic joints
Artificial heart valve	Diabetes type 1/type 2	Psychiatric care
Asthma	Epilepsy	Radiation/chemotherapy
Blood disorder (name below)	Hearing impairment	Reflux
	Heart disease	Rheumatic fever
Blood pressure (high/low)	Heart murmur	Steroid therapy
Blood thinner	Hepatitis A/B/C/D	Stroke
Bone disease (e.g. Osteoporosis)	HIV positive	Thyroid disorder
Current or past	Immune deficiency	Other condition(s) (name below)
Bisphosphonate therapy	Kidney/liver disease	
Cancer	Neurological disorder	

Medical history (continued)

Are you pregnant? Yes No If yes, how many months?

Are you Aboriginal or Torres Strait Islander? Yes No

Are you taking medication (including natural supplements)? If yes, please list:

Are you a smoker? Yes No If yes, how often?

Allergies

Aspirin Iodine Latex Penicillin Sulpha drugs

Other (please specify):

Dental history

Last dental visit: Is there a particular reason for your visit today?

Have you ever had a reaction or complication following dental treatment in the past? Yes No

If yes, please detail:

Is there anything else the dentist or hygienist should be aware of?

Do you generally feel anxious about seeing your dentist and/or hygienist?

Yes - extremely Yes - very Yes - somewhat No - not at all

Are you suffering from any of the following?

Bad appearance of teeth	Discoloured teeth	Lost filling/cavity	Toothache
Bad breath	Dry mouth	Rapidly decaying teeth	Unsatisfactory denture
Bleeding gums	Grinding/clenching	Pain in face/jaw	Worn or broken teeth
Difficulty chewing	Missing teeth	Sensitive teeth	
	Loose teeth	Sounds from joints	

Have you ever had a sleep study and been diagnosed with sleep apnoea? Yes No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? Yes No

Has anyone ever told you that you snore? Yes No

After 6-7 hours of sleep do you wake up refreshed? Yes No

How did you find out about us?

Google Signage TV Radio Print ad Referred by doctor:

Other (please specify): Referred by friend/family:

Privacy policy and signature

All personal information collected by Bupa Dental Corporation is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information. You can view the policy online at <https://www.dentalcorp.com.au/australian-privacy-policy/>.

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient/Legal guardian name:

Signature:

Date:

OFFICE USE ONLY.

Form checked by _____ Data keyed by _____ Keying checked by _____ Form scanned by _____