Sunshine family dental
Helping the nation smile

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.

Personal Details

Title: Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Surname ____________________ DOB ____________________

Given Name ____ Occupation ____

Address ____

Suburb _____________ Postcode _________ Phone (Home) __________________ Phone (Mobile) ___________________

Email Address ____

GP Clinic Name and Doctor's Name ____

Health Fund Details (if applicable) ____

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

How did you find out about our clinic? ☐ Signage ☐ Newspaper ☐ Internet – google search/website
☐ Friend/family, name ___________________ ☐ Medical Clinic, name ________________________________
☐ Others, please specify ____

Health Details

Do you have, or have you ever had any of the following conditions? Please tick if yes or cross if no.

☐ Allergies
☐ Arthritis
☐ Artificial Joints
☐ Bone Disorders (eg. osteoporosis)
☐ Cancer or tumour
☐ Diabetes
☐ Epilepsy/ Neurological Disorder
☐ Fainting or dizziness
☐ Heart Problems/ Surgery
☐ High or low blood pressure
☐ Hepatitis B or C
☐ HIV/AIDS
☐ Kidney or liver disease
☐ Mental health issues
☐ Radiation to head or neck
☐ Respiratory problems
☐ Sinus problems
☐ Bruise or bleed easily
☐ Are you, or suspect you may be pregnant? ☐ Bisphosphonate treatment? (eg. atonel, zometa, fosamax)

Do you smoke or use other forms of tobacco? If so, how many cigarettes do you smoke per day?

____

Current medication ____

Dental History

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

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

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

☐ Discoloured teeth
☐ Sensitivity
☐ Missing teeth
☐ Pain in jaw
☐ Broken teeth
☐ Denture issues
☐ Gum problems
☐ Snoring

I understand that payment is required on day of treatment unless otherwise arranged.
I understand that more than 24 hours is required for rescheduling of appointments.

______________________________ ______________________________
Patient/Guardian Signature Date