Sunshine family dental
Helping the nation smile

New Patient & Dental History

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. We ask that you complete a new form every 2 years or sooner, if your medical history changes significantly.

Personal Details

Title: Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Mx ☐

Surname:_____ Given Name: _____

DOB: _____ Occupation: _____

Address: _____ Suburb: _____ Postcode: _____

Email Address: _____ Phone: _____

GP Clinic Name and Doctor's Name: _____

Health Fund Details (if applicable): _____

Name of parents/legal guardians if under 18: _____

How did you find out about our clinic? ☐ Signage ☐ Newspaper ☐ Internet – Google search/Facebook/Website
☐ Friend/family, name:_____ ☐ Medical clinic, name: _____
☐ Other, 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:_____
- ☐ Diabetes
- ☐ High or low blood pressure
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Respiratory (breathing) problems
- ☐ Sinus problems
- ☐ Kidney or liver disease
- ☐ Hepatitis B or C
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Bone disorders (e.g. Osteoporosis)
- ☐ Heart problems/surgery
- ☐ Prosthetic heart valve replacement/ Prosthetic heart valve repair
- ☐ Previous infective endocarditis
- ☐ Congenital heart disease
- ☐ Bleeding disorders
- ☐ Bruise or bleed easily
- ☐ Fainting or dizziness
- ☐ Epilepsy/ Neurological disorder
- ☐ Mental health issues
- ☐ HIV/AIDS
- ☐ Cancer or tumour
- ☐ Radiation to head or neck

☐ Bisphosphonate/monoclonal antibody treatment? (E.g. Actonel, Fosamax, Prolia)
☐ Are you, or suspect you may be pregnant? ☐ Are you currently breast feeding?
☐ Do you vape or smoke (tobacco, marijuana, etc.)? If so, how many cigarettes do you smoke per day?_____
☐ Do you drink alcoholic beverages? If so, how many drinks do you have per week? _____
☐ Have you been told you require antibiotics by your doctor/specialist prior to dental treatment?

Current medication(s): _____

Current supplement(s): _____

Approximate weight (kg): _____

Dental History

What are your greatest concerns and needs for your dental treatment? _____
How long has it been since you have seen a dentist? _____

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

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

I understand that payment is required on the day of treatment unless otherwise arranged.
I understand that more than 24 hours is required for rescheduling of appointments, otherwise a cancellation fee of $50 or 30% of treatment cost (whichever is greater), may incur. Deposits may be required from time to time, at the clinic's discretion.

_____ _____
Patient/Guardian Signature Date