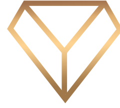

NORTH SYDNEY
DENTAL IMPLANTS

NEW PATIENT INFORMATION FORM

ABOUT YOU

Welcome to our office. We appreciate the confidence you have placed in us to provide you with dental care. To assist us in providing the best possible care, please complete the following form. The Information provided on this form is important to your dental health and will be treated with the strictest confidence. If you have any questions, please don't hesitate to ask.

Full Name: .... TITLE .... FIRST NAME .... SURNAME ....

Name I'd like to be called: .... Birth date: ....

Address: ....

.... Post Code: ....

Occupation: .... Employer: ....

Business Address: ....

Telephone - Home: .... Work: .... Mobile / SMS: ....

E-mail address: ....

Other family members seen by us: ....

Who may we thank for referring you? ....

When and how are the best times to reach you? ....

BILLING INFORMATION

Person responsible for paying this account? ....

Relationship to patient: ....

Billing address: ....

.... Post Code: ....

Medicare Number: .... Position on Card: .... Valid To: ....

Method of payment will be (please tick): ◯ Cash ◯ Cheque ◯ Credit / Debit card ◯ Third Party Financing

FURTHER INFORMATION

Spouses Name: ....

Telephone: Home .... Work: .... Mobile: ....

Name of neighbour or relative not living with you: ....

Relationship: ....

Telephone: Home .... Work: .... Mobile: ....

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes / No

If yes, for what? ....

Physician's Name: .... Phone: ....

Address: .... Postcode: ....

Please list all physicians/specialists seen in the last 5 years:

Physicians/specialists Name	Contact Number/Address (if known)	Ailment Treated	Date Treated

Are you currently taking any medication, drugs or pills? Yes / No

If yes, please list name and dosage: ....

Do you smoke? Yes / No If yes, how many per day? ....

Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes / No

If yes, please list: ....

Have you been a patient in the hospital during the past five years? Yes / No

If yes, why: ....

Indicate which of the following you have had, or have at present. Please circle yes or no to each item.

Heart (surgery, disease, attack)	Yes / No	Diet (special/restricted)	Yes / No	Cold Sores/Fever Blisters	Yes / No
Chest Pain	Yes / No	Stomach Ulcers	Yes / No	Haemophilia	Yes / No
Congenital Heart Disease	Yes / No	Diabetes	Yes / No	Bruise Easily	Yes / No
Heart Murmur	Yes / No	Thyroid Problems	Yes / No	Liver Disease	Yes / No
Hight Blood ressure	Yes / No	Chronic Cough	Yes / No	Kidney Trouble	Yes / No
Mitral Valve Prolapse	Yes / No	Tuberculosis	Yes / No	Neurological Disorders	Yes / No
Artificial Heart Valve	Yes / No	Asthma	Yes / No	Epilepsy or Seizures	Yes / No
heart Pacemaker	Yes / No	Hay Fever	Yes / No	Faiting or Dizzy Speells	Yes / No
Rheumatic Fever	Yes / No	Latex Sensitivity	Yes / No	Nervous/Anxious	Yes / No
Arthritis/Rheumatism	Yes / No	Sinus Troubles	Yes / No	Artificial Joints (hip, knee etc)	Yes / No
Cortisone Medicine	Yes / No	Radiation Therapy	Yes / No	Tumours	Yes / No
Swollen Ankles	Yes / No	Chemotherpay	Yes / No		

Do you have or have you had any disease, condition or problem not listed? Yes / No

If yes, please list: ....

Women - are you: **Pregnant?** Yes / No / Possibly If yes how many weeks: ....

Nursing? Yes / No **Taking birth control pills?** Yes / No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist/hygienist of any change in my health or medication.

Signature: Date:

DENTAL HEALTH HISTORY

In an effort to provide wholistic dental care, please take the time to answer the following questions.

Why did you leave your last dentist? ....

What do you want in a dentist? ....

Have you had a bad dental experience? If so, please explain: ....

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ....

When was your last dental appointment? ....

What did you have done? ....

What prompted you to seek dental care at this time? ....

What do you feel is the most important thing we can do for you at this time? ....

Do you play any contact sport that may require a mouth guard? If so, which sport? ....

How long since your last thorough examination / full mouth x-rays? ....

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ....

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-coloured restoration instead? ....

Does food constantly get stuck between your teeth? ....

Are you dissatisfied with your teeth in any way? ....

If you could change one thing about your smile what would it be? ....

Are you dissatisfied with the way your teeth look? For example: Colour, Shape, Spaces etc. ....

Do you have any fillings that show in your front teeth? .... Do any of your fillings show when you smile? ....

Have you ever had any teeth removed? .... How long have these teeth been missing? ....

Are your teeth sensitive to? (please circle) Heat Cold Sweets Biting / Pressure

Do your gums bleed when brushing? .... Do you ever avoid any part of the mouth while brushing? ....

Have you been instructed regarding proper home care? .... Do you have an unpleasant taste or odour in your mouth? ....

Do you frequently snack between meals or chew gum? .... How often do you brush your teeth? ....

How often do you use floss? .... Do you want to learn to control dental disease and retain your teeth? ....

Do you snore? .... Have you been told you suffer from Obstructive Sleep Apnoea (OSA)? ....

Are you tired or listless during the day? (If Yes please explain) ....

Do you have or have you had any of the following? Please tick any that apply.

Frequent Headaches	◯	Facial Pain	◯
Pain Behind the Eyes	◯	Neck Pain	◯
Jaw Joint Pain	◯	Postural Problems	◯
Jaw Joint Noise	◯	Numbness on the back of your Hands	◯
Limited Opeining of your Mouth	◯	Tingling Fingers	◯
Ear Congestion	◯	Back Pain	◯
Ringing in the Ears	◯	Trauma to the Jaw or Face	◯
Difficulty Swallowing	◯	Trauma to the Head or Neck	◯
Clenching/Grinding your Teeth	◯		

If you have ticked any of the above, please elaborate: ....

....

CONSENT

I understand that, to the best of my knowledge the questions on this form have been accurately answered. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or condition.

I authorise the dental staff to perform all necessary dental procedures that I may need with my informed consent. I also give permission to the dentist or his staff to use any photos he may take to be used for lecturing, publishing or educational purposes.

Signature: Dated:

To make your visit more comfortable, we have a selection of beverages, music and DVD's available to you. Please ask your treatment coordinator to supply you with our comprehensive list.

If you would like anything to make your visits with us more enjoyable, please don't hesitate to let our treatment coordinator know.

Thank you

NORTH SYDNEY
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