New Patient Information Form

Welcome to The Dental Studio. We appreciate the confidence you have placed in us to provide your 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. If you have any questions, please don't hesitate to ask.

1 About You

Full Name: ______________________________
Title First Name Middle Name Surname

Name I'd like to be called: ______________________________

Birthdate: ______________________________

Address: ______________________________

Suburb: ______________________________ Post Code: __________

Occupation: ____________________ Employer: ____________________

Business Address: ______________________________

Telephone - Home: __________ Work: __________ Mobile: __________

E-mail address: ______________________________

Other family members or friends seen by us: ______________________________

Who may we thank for referring you? ______________________________

When and where are the best times to reach you? ______________________________

What is your preference for communication from our practice?

☐ Home Phone ☐ Work Phone ☐ Mobile ☐ Email

2 Billing Information

Method of payment will be: ☐ Cash ☐ Cheque ☐ Visa / Mastercard ☐ American Express ☐ Debit Card

Dental Private Health Fund ______________________________

Person responsible for paying this account on the day of treatment? ______________________________

Relationship to patient: ______________________________

3 Emergency Contact

In the unlikely event of an emergency, whom may we contact?

Name: ______________________________

Telephone - Home: __________ Work: __________ Mobile: __________

Relationship to you: ______________________________

4 Medical Health History

Name of Medical Practitioner ______________________ Phone Number ______________

Are you taking any medications or supplements at present, both prescribed or over the counter? ______________

____

____

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 hospital during the past two years? Yes / No Why: ______________

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

Heart (surgery, disease, attack)	Yes / No	MedicAlert ______	Yes / No	Radiation Therapy ______	Yes / No
Chest Pain ______	Yes / No	Stroke ______	Yes / No	Chemotherapy ______	Yes / No
Congenital Heart Disease ______	Yes / No	Diet (Special/Restricted) ______	Yes / No	Cold Sores/Fever Blisters ______	Yes / No
Heart Murmur ______	Yes / No	Stomach Ulcers ______	Yes / No	Haemophilia ______	Yes / No
Hepatitis ______	Yes / No	Diabetes ______	Yes / No	Bruise easily ______	Yes / No
High Blood Pressure ______	Yes / No	Thyroid Problems ______	Yes / No	Liver Disease ______	Yes / No
Mitral Valve Prolapse ______	Yes / No	Chronic Cough ______	Yes / No	Kidney Trouble ______	Yes / No
Artificial Heart Valve ______	Yes / No	Tuberculosis ______	Yes / No	Neurological Disorders ______	Yes / No
Heart Pacemaker ______	Yes / No	Asthma ______	Yes / No	Epilepsy or Seizures ______	Yes / No
Rheumatic Fever ______	Yes / No	Eating Disorder ______	Yes / No	Fainting or Dizzy Spells ______	Yes / No
Arthritis/Rheumatism ______	Yes / No	Hay Fever ______	Yes / No	Nervous/Anxious ______	Yes / No
Cortisone Medicine ______	Yes / No	Latex Sensitivity ______	Yes / No	Artificial Joints ______	Yes / No
HIV ______	Yes / No	Sinus Troubles ______	Yes / No	Tumours ______	Yes / No

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

If yes, please list: ____

____

Female Patients

Are you pregnant? Yes - Months: ____ / No **Nursing?** Yes / No

Taking birth control pills? Yes / No

Do you think you may be pregnant? 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 of any change in my health or medication.

5 Dental History

How long since your last dental examination and full mouth xrays? ______

How often do you have dental examinations? ______

Previous dentists name and address: ______

Have you had any complications during or following previous dental treatment? ______

How often do you brush your teeth? ______

How often do you floss? ______

Do you play any contact sport that may require a mouthguard? If so, which sport? ______

Do you have an unpleasant taste or odour in your mouth? Yes/No

Does your jaw 'click' or hurt? ______ Yes/No

Do you feel you grind your teeth? ______ Yes/No

Do you use a dental nightguard/splint? ______ Yes/No

Have you had orthodontic treatment (braces)? ______ Yes/No

Have you had periodontal (gum) treatment? ______ Yes/No

Have you had dental implants? ______ Yes/No

Do you bite your lips or cheeks? ______ Yes/No

Does food get caught between your teeth? ______ Yes/No

Does floss tear between your teeth? ______ Yes/No

Do your gums ever bleed when you clean your teeth? ______ Yes/No

Do you experience sensitivity with hot or cold foods/drinks? Yes/No

Do your teeth ever hurt to bite or chew with? ______ Yes/No

Do you have any missing teeth you would like replaced? ______ Yes/No

Are you concerned with your ability to eat? ______ Yes/No

Are you concerned with existing crowns, bridges or dentures? Yes/No

Is there anything else about previous or future dental treatment you would like us to know? If yes, please describe:

______

______

Is there a main concern that has prompted your visit today? If yes, please describe:

______

______

6 Your Consent

I understand that to the best of my knowledge the questions on this form have been answered accurately. I understand that it will be held in the strictest of confidence and that it is my responsibility to inform this surgery 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 hereby consent to the use of any study models, xrays, computer images or photographs to be used for any lecturing, publishing or educational purposes.

I understand that the practice requires **at least 48hrs notice to cancel an appointment** and that a fee based on the time reserved for that appointment will be incurred should I fail to do so.

I understand that I am responsible for the fees associated with any dental procedure and am aware that payment is required on the day of treatment.

Signature: ______ **Date:** ______

7 Practice Policies

Payment

The Dental Studio requires payment on the day of your treatment. We accept Cash, EFTPOS, American Express, Visa and MasterCard.

We also offer a HICAPS facility, which allows you to claim your treatment costs at the time of your visit if you are privately insured. However, the amount covered by any health insurance provider is an agreement between yourself and your health insurance provider solely.

Appointment Times

We appreciate that your time is valuable and so we make every endeavour to be on schedule. To help us stay on time, we ask you to arrive five minutes before your reserved appointment. Emergencies and unforeseen circumstances may occasionally cause a delay, for which we apologise and seek your understanding and patience.

Cancellation of appointments

If you are unable to keep your appointment, please notify us as soon as possible. Due to the high demand at our practice, a fee for missed appointments is charged, including those cancelled within 48 hours of your scheduled appointment.

Privacy

At The Dental Studio, patient privacy is taken very seriously. Not only do we adhere to strict confidentiality regulations, but we also provide an environment that offers privacy throughout your visit. You can be confident your consultations are handled with complete discretion, your details are stored securely and your information is not disclosed without your consent.

Your Rights

During your treatment we will:

1. Give you a clear explanation of the planned treatment and obtain your consent for the treatment. This will include discussing possible complications.
2. Wherever possible we will give you an indication of the cost of your treatment. This initial estimate could vary during the course of your treatment if the treatment needs to change.
3. Treat you with courtesy and respect at all times.

Your Responsibilities

1. Be sure that you are well informed about the proposed treatment, as well as your role in managing your personal oral health.
2. Answer our dentist's questions about your health and medical problems honestly; as such problems may affect your treatment.
3. Inform us about any change in your health and/or medications you are taking if these have changed since your last visit.
4. Be responsible for the cost of treatment by an external specialist if you have been referred to one by our dentist's. If you do not attend, this may affect the management or the outcome of your treatment.
5. Ensure your personal details including your address and telephone numbers recorded are up to date. Please inform our staff of any changes at your earliest convenience.
6. Treat us and other patients with respect and courtesy.
7. Conduct yourself in an appropriate way so as not to interfere with the well being and rights of other patients or staff.
8. To ensure everyone's safety, please abide by all reasonable instructions that staff may give you when you are within the practice.

I have read, understood and agree to The Dental Studio's practice policies. If you require a signed copy for your records, please ask our Front Office Coordinator.

Print Name: ______________________________

Signature: ______________________________ **Date:** ______________________