GO SMILES DENTAL STUDIO

NEW PATIENT INFORMATION

Name (Mr/Mrs/Miss/Dr): First Name:___________________________________ Last Name: _____________________________________

Address:____ Post Code : __________________

DOB: __ __ /__ __ /__ __ __ __ E-Mail:____ Occupation: _____________________________

Phone: Mobile: ____________________________ Home: __________________________ Work: _________________________________

Emergency Contact: _________________________ Relationship: ____________________ Contact No. ___________________________

Dental Private Health Cover (Y / N) Fund Name:______________________________ Membership Number: _______________________

Medicare Card No: __________________________ Vet Affairs Card No: _____________________

How will you be settling your account today? Cash / Credit Card / EFTPOS / Other: ____

MEDICAL QUESTIONS – PRIVATE AND CONFIDENTIAL

PLEASE ANSWER THESE QUESTIONS AS COMPLETELY AS POSSIBLE AS THESE MAY HAVE SIGNIFCANT EFFECT ON YOUR DENTAL CARE

Do you wish to discuss private and confidential medical matters with the dentist	Y	N
Are you receiving any medical treatment at present?	Y	N
Name of your medical practitioner/specialist		
Have you ever been hospitalised during the last 5 years	Y	N
Have you ever had or are you currently receiving treatment for cancer? Details: ____	Y	N
List any medicines you are taking (including oral contraception, HTR, naturopathic, herbal and over the counter medicines) ____	Y	N

PELASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

When was your last dental visit? ________________________			Tuberculosis (TB)	Y	N
Rheumatic Fever	Y	N	Depression / Anxiety Disorder	Y	N
Any Cardiac (Heart) Complaint	Y	N	Epilepsy	Y	N
Any Cardiac (Heart) Surgery	Y	N	Nervous System disorder	Y	N
A Cardiac pace Maker	Y	N	Thyroid Disease (Including Goiter)	Y	N
High or low blood pressure	Y	N	Asthma	Y	N
Anti-Coagulant (Blood Thinning) Medication	Y	N	Gastric Ulcer	Y	N
Blood Disorders	Y	N	Do you smoke If Yes, For ____ Years. How Many Per day? _______	Y	N
Do you have AIDS or HIV?	Y	N			
Excess brushing or bleeding	Y	N	Dry Mouth	Y	N
Osteoporosis or low bone density	Y	N	Snoring or Sleep Apnoea		
Bisphosphonate treatment	Y	N	CPAP machine	Y	N
Joint replacement surgery	Y	N	Are you pregnant?	Y	N
Diabetes Type : ________________________________	Y	N	Are you Breastfeeding?	Y	N
Family history of Diabetes	Y	N	Allergy or reaction to any medicine (Including penicillin or other antibiotics)	Y	N
Hepatitis Type (A,B,C,D,E) : _____________________	Y	N			
Jaundice or liver disease	Y	N	Allergy to any food or substance (Such as Chlorine, latex, antiseptics)	Y	N

Would you like to discuss any of the following:

Replacement of missing teeth Cosmetic appearance Removal of wisdom teeth Crowns Veneers Tooth whitening Bad breath

Bleeding gums Tooth grinding / Clenching Root canal treatment Replacement of fillings Dentures Implants Orthodontics

Others ____

In signing this form I acknowledge that this represents an accurate medical history
I understand that all medical details will be treated with complete professional confidentiality
I agree to accept any cost or fee incurred directly or indirectly by Go Smiles Dental Studio for the recoveries of monies due to an outstanding account

Name/Guardian :________________________________ Date :_____________________Mobile Number: _________________________

Signature________________________________ Address____