New Patient Form

Gentle Care Dentistry

Welcome to Gentle Care Dentistry and thank you for choosing us. We would like you to enjoy your visit and if there is anything we can do to help improve your experience, please don't hesitate to let us know. We have free WIFI available—please ask staff for details.
In order to render dental treatment of a high standard, it is necessary to have the following information, which will be handled confidentially. Please fill in this form completely.

Title: Mr / Mrs / Ms / Miss / Master / Dr / Prof / Mx / Other:
Surname: _____ First Name: _____
Preferred Name: _____
Date of Birth: (DD/MM/YYYY) _____
Address: _____
Suburb: _____ Postcode: _____
Phone (Home): _____ (Mobile): _____
Email: _____
Occupation: _____ Are you covered for dental treatment (which fund?) _____
Emergency contact **name** and **number**: _____
How did you hear about this practice/referred by? _____

Medical and Dental History (*Please circle)*

Have you ever had **heart trouble** or **high blood pressure**? _____ Yes / No
Have you ever had **rheumatic fever**, **diabetes**, **asthma**, **cancer**, **anaemia**, **arthritis**, **nervous disorders**, **neurological disorders**, **neurodevelopmental disorder**, **osteoporosis** or **ANY chronic condition**?
If yes, please specify _____ Yes / No
Are you taking any drugs or **medication**? _____ Yes / No
If yes, please specify _____

Name of your doctor/GP and Contact Number: _____
Do you suffer from, or have any reason to suspect you have **Hepatitis, HIV, AIDS** or any other infectious diseases? _____ Yes / No
If yes, please specify _____
Have you ever had any other serious illness? _____ Yes / No
Have you been a patient in hospital during the past two years? _____ Yes / No
Are you under current medical treatment? _____ Yes / No
Have you any known **allergies** to drugs (especially penicillin), antiseptics (e.g. chlorhexidine), latex or dental injections? _____ Yes / No
Have you ever experienced prolonged bleeding? _____ Yes / No
[Female] If pregnant, please state how many months _____
Are you a cigarette smoker? How many per day _____ Yes / No
Are you aware of any jaw clenching or grinding of your teeth? _____ Yes / No
When was your last dental visit? (How many months/ years ago?) _____

Reason for Today's Visit *(Please Circle)*
Check up and Clean | Consultation | Toothache | Filling | Extraction | Implant | Crown | Cosmetic Injectables
Other: _____
Are you considering any cosmetic dental work (e.g. teeth whitening, veneers) _____ Yes / No

Method of Payment: Cash | Credit | EFTPOS | DVA | Voucher | Child Dental Benefits Schedule
How would you like to receive your reminder for future check-ups? _____ SMS / Letter

I give **consent** for an oral examination, dental radiographs and relevant investigations and tests

Signature: ✕_____ Date: _____