NEW PATIENT HISTORY FORM

KAPUNDA DENTAL

Today's Date _____

Title (Mr/Mrs/Miss/Ms/Other) _____

First Name_____

Surname _____

Contact Number_____

Address (Postal) _____

_____

Postcode _____State _____

Date of Birth _____Gender _____

Email _____

Preferred method of contact _____

Do you recognise as Aboriginal/Torres Strait Islander?

YES / NO /Other_____

Occupation _____

How did you hear about us? _____

Emergency Contact Name/No._____

Relationship/Parent_____

Are you responsible for payment of accounts?

Yes/No/List Name_____

Private Health Fund/DVA Name (if applicable)

_____

Medicare Number: _____

IRN/Expiry: _____

Is your family eligible for Child Dental Benefit Scheme?

YES / No / Unsure

MEDICAL HEALTH DETAILS

Do you have, or have you ever had any of the following conditions?	Yes	No	Details/Comments
Allergies (eg. penicillin, latex, codeine)	☐	☐	
Sinus problems/ENT history	☐	☐	
Respiratory problems (eg. Asthma/COPD)	☐	☐	
Epilepsy or other neurological disorder	☐	☐	
Fainting or dizziness	☐	☐	
Hepatitis B or C, HIV/AIDS, autoimmune disease	☐	☐	
Heart problems (eg. heart attack, angina, stroke, murmur)	☐	☐	
Heart surgery (eg. by-pass, valve replacement, pacemaker)	☐	☐	
High or low blood pressure	☐	☐	
Kidney or liver disease	☐	☐	
Organ transplant or joint replacement	☐	☐	
Diabetes	☐	☐	
Cancer or tumour (current, historical or head/neck radiation)	☐	☐	
Bone disorders (eg. osteoporosis, pagets disease)	☐	☐	
Have you ever taken bisphosphonates? (eg.Fosamax, Actonel, Prolia)	☐	☐	
Are you taking blood thinners or bruise/bleed easily?	☐	☐	
Do or have you ever smoked, vaped or used other forms of tobacco?	☐	☐	
Are you, or do you suspect you may be pregnant (no. weeks)?	☐	☐	
Mental health condition	☐	☐	
Are you receiving any current medical treatment and/or been hospitalised in the last 12months?	☐	☐	

MEDICAL HEALTH DETAILS CONTINUED.

KAPUNDA DENTAL

GP/Doctors Name _____Phone _____

Address_____ Post Code_____

Are you taking and medications (incl. supplements, herbal preparations and vitamins): YES / NO

If Yes, please list name, frequency and dosage

_____

_____

_____

Consent for Kapunda Dental to communicate with GP to access current medication list YES / NO (please circle)

Do you have any allergies? YES/NO

If yes, please list_____

_____

DENTAL HEALTH DETAILS

When was your last dental visit _____ What was done at last dental visit? _____

Do you have any dental concerns today? YES / NO

If yes, please describe_____

Do you have or are you aware of any of the following conditions?	Yes	No	Details/Comments
TMJ/Jaw concerns incl. grinding/clenching/wear a guard?	☐	☐	
Have you ever had orthodontic treatment?	☐	☐	
Have you had your wisdom teeth removed/oral surgery?	☐	☐	
Is there anything you dislike about the appearance of your teeth?	☐	☐	
Do you suffer from dry mouth or bad breath?	☐	☐	
Do your gums bleed when you brush?	☐	☐	
Does food get caught in your teeth?	☐	☐	
Are any of your teeth loose or sore?	☐	☐	
Are any of your teeth sensitive to hot, cold, pressure?	☐	☐	
Do you use a manual or electric toothbrush (times/day)?	☐	☐	
Do you floss, use toothpicks or interdental brushes?	☐	☐	
Do you play contact sport and wear a mouthguard?	☐	☐	
Do you experience anxiety when visiting a dental clinic?	☐	☐	
Have you ever experienced dental trauma?			

Is there anything else you would like us to know that may help to make your dental visit more comfortable?

_____

CONSENT FOR TREATMENT

1. I have answered all questions to the best of my knowledge. Should further information be required, you have permission to contact my medical practitioner, who may release such information to you.

2. I consent to a dental practitioner to take radiographs, study models, photographs and other diagnostic aids as deemed appropriate by a dental practitioner to make a thorough dental diagnosis.

3. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. I also understand that if for any reason recovery of funds is required, and costs involved will be at my expense. I understand that if I cancel an appointment within 24 hours of my appointment, I may be liable for payment of a cancellation fee.

4. I agree to the clinical team using any photographs and radiographs they take for educational purposes if discussed.

Patient Name_____ Date_____

Patient Signature_____ Parent/Guardian _____

WE RESPECT YOUR PRIVACY

Please read this Privacy Collection Statement to see how we use personal information.

Kapunda Dental collect, handle, use and protect your personal information in accordance with the Privacy Act 1988 (Cth) and our Privacy Policy which can be viewed in full on our website. Alternatively, please ask our reception team for a copy of our privacy Policy.

We collect your personal information to provide you with products and services you have requested, improve out products and services, keep you informed of your upcoming appointments and notify you about out latest promotions and other offers relevant to you. We collect this information mainly through our communications with you, but we may do so also from other sources in the course of providing our services to you. You are not obliged to provide us with your personal information. However, this may impact the ability to provide you with our products and services. We generally do not disclose information about you to any person and will only share your personal information where necessary to provide you with products and services, as required by the law, or with your permission.

Name_____ Signature _____ Date_____