SAILORS BAY DENTISTRY

Form Complete:
Details updated in computer:
Signature:

# WELCOME TO OUR PRACTICE

*At Sailors Bay Dentistry we strive to provide you with the highest possible care. To do this we need to collect personal information from you that include contact details and matters pertaining to your general health, both past and present. Without this information it is difficult for your dentist or hygienist to plan your care properly.*

*Please be assured that this information is maintained in accordance with State and Federal Privacy Legislation. If you would like any further information about how we use and protect your personal information, please ask one of our staff for our brochure "Personal Information, Privacy and your Dentist".*

**Surname:** **Title:** **Given Name:**

**M** ☐ **F** ☐

**Preferred Name:** **Date of Birth:**

| **Address:** | **Suburb:** | **Postcode:** |
|---|---|---|

**Home Phone:** **Mobile:**

**Work:**

***Email Address:***

We will send you email communications from time to time, including our regular newsletter and offers.

☐ Please tick this box if you don't wish to receive communication from us.

**Vet Affairs Gold / White** please circle **Vet Affairs Card Number:** **Expiry Date:**

**Name of Private Health Fund (if any)** **Position No on card:**

**Occupation:** **Employer Name:**

**Next of Kin**

**Name:** **Relationship** **Phone:**

**In case of an emergency whom should we contact?** Please indicate if different to next of kin.

**Name:** **Relationship:** **Phone:**

**Courtesy Reminder System:**
*Please indicate the preferred means of contact.*
☐ SMS to Mobile ☐ Call mobile ☐ call home phone ☐ call work phone

**Routine Maintenance Reminder**
We will remind you when you are due for a routine maintenance (check-up) appointment every 6 or 12 months. If you do not want us to remind you please indicate below.
☐ No, don't remind me, I will contact the practice for an appointment.

**Email Updates:**
To be kept informed with updates on what is new in my practice, services and new dental techniques that may affect my next visit.
☐ No ☐ Yes

Form Complete:
Details updated in computer:
Signature:

**How did you hear about us?**

☐ Referred by another patient ***who****?* ________________ ☐ Referred by staff **who***?* __________________

☐ White pages ☐ Google search ☐ Practice Website ☐ Corporate Dental Program
☐ Dental Care Network™ ☐ New Patient Offer ☐ Signage/Passing by ☐ golf club
☐ GP or other Dr's ☐ Advertisement ☐ Health Fund ☐ Facebook

Other**:** _____________________

**Dental History**

How long is it since your last thorough dental examination?

☐ 6 months ☐ 1 year ☐ 2years ☐ 3 years ☐ longer

**Please tick any dental concerns you have?**

| | | |
|---|---|---|
| ☐ Toothache | ☐ Missing teeth | ☐ Pain in face or jaw joints |
| ☐ Sensitive teeth | ☐ Unsatisfactory denture | ☐ Sounds from joint |
| ☐ Bleeding gums | ☐ Rapidly decaying teeth | ☐ Difficulty chewing |
| ☐ Loose teeth | ☐ Lost filling/cavity | ☐ Discoloured teeth |
| ☐ Bad breath | ☐ Grinding/clenching teeth | ☐ Bad appearance of teeth |
| ☐ Dry mouth | ☐ Worn, broken teeth | ☐ Do you, or have you ever smoked? |
| | ☐ Sick of ticking boxes? | |

**Medical History**

*How do you rate your general health?* ☐ Excellent ☐ Good ☐ Poor ☐ Fair

Who is your General Practitioner? _________________________ Telephone: ____________________

***Have you had or are you suffering from any of these? (please tick those applicable)***

| | |
|---|---|
| ☐ Heart Trouble / Surgery | ☐ Nervous Disorders |
| ☐ Cardiac Pacemaker | ☐ Asthma |
| ☐ High blood pressure | ☐ HIV/AIDS |
| ☐ Low blood pressure | ☐ Liver or kidney disease |
| ☐ Diabetes ☐ type 1 ☐ type 2 | ☐ Are you or could you be pregnant? |
| ☐ Hepatitis ☐ A ☐ B ☐ C | ☐ Excessive or prolonged bleeding |
| ☐ Rheumatic Fever | ☐ Radiation or chemotherapy |
| ☐ Arthritis | ☐ Eating disorder |
| ☐ Thyroid trouble | ☐ Prosthetic implant/joint replacement |
| ☐ Epilepsy | ☐ Organ or bone marrow transplant |
| ☐ Sleep Apnoea / snoring / restless sleep | ☐ Steroid therapy |
| ☐ Stroke | ☐ Cold sores |
| ☐ Stomach or digestive condition/reflux | ☐ Other (specify) __________________ |
| ☐ Osteoporosis | ☐ Do you smoke? |

**Are you allergic to anything eg local anaesthetic, latex, penicillin, peanut, etc (please specify)**

**What medications including natural remedies are you taking? (please list)**

All personal information collected by Sailors Bay Dentistry is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information. You can view the policy online at https://www.dentalcorp.com.au/australian-privacy-policy/.

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment

Form Complete:
Details updated in computer:
Signature:

of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient signature: ________________________ Print Name: ________________________ Date: _________

(Parent or Guardian to sign if patient is a minor)

Checked by: ____________________________ Print Name: ________________________ Date: _________