

# New Patient Information Form

## Welcome to our office.

We appreciate the confidence you have placed in us to provide you with "Dental Excellence". 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 Surname

Name I'd like to be called: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Post Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile / SMS: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

When and where are the best times to reach you? \_\_\_\_\_

## 2. BILLING INFORMATION

Person responsible for paying this account? \_\_\_\_\_

Billing address: \_\_\_\_\_ Post Code: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Method of payment will be:

 Cash

 Cheque

 Credit / Debit card

 Mediplan

## 3. FURTHER INFORMATION

Spouses Name: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Nearest neighbour or relative not living with you:

His / her name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

**All Information Will Be Treated With Complete Professional Confidentiality.**

## 4. MEDICAL HEALTH HISTORY

Have you been under the care of a medical doctor during the past two years? Yes / No

If yes, for what? \_\_\_\_\_

Please list all physicians/specialists seen in the last 5 years:

| Physicians/specialists Name | Contact Number/Address (if known) | Ailment Treated | Date Treated |
|-----------------------------|-----------------------------------|-----------------|--------------|
| _____                       | _____                             | _____           | _____        |
| _____                       | _____                             | _____           | _____        |

Are you taking any medication, drugs or pills now? Yes / No

If yes, please list name and dosage: \_\_\_\_\_

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 the hospital during the past five 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 | Diet (Special/Restricted) | Yes / No | Haemophilia              | Yes / No |
| Chest Pain                       | Yes / No | Stomach Ulcers            | Yes / No | Bruise easily            | Yes / No |
| Congenital Heart Disease         | Yes / No | Diabetes                  | Yes / No | Liver Disease            | Yes / No |
| Heart Murmur                     | Yes / No | Thyroid Problems          | Yes / No | Kidney Trouble           | Yes / No |
| High Blood Pressure              | Yes / No | Chronic Cough             | Yes / No | Neurological Disorders   | Yes / No |
| Mitral Valve Prolapse            | Yes / No | Tuberculosis              | Yes / No | Epilepsy or Seizures     | Yes / No |
| Artificial Heart Valve           | Yes / No | Asthma                    | Yes / No | Fainting or Dizzy Spells | Yes / No |
| Heart Pacemaker                  | Yes / No | Hay Fever                 | Yes / No | Nervous/Anxious          | Yes / No |
| Rheumatic Fever                  | Yes / No | Latex Sensitivity         | Yes / No | Artificial Joints        | Yes / No |
| Arthritis/Rheumatism             | Yes / No | Sinus Troubles            | Yes / No | (hip, knee, etc.)        | Yes / No |
| Cortisone Medicine               | Yes / No | Radiation Therapy         | Yes / No | Tumours                  | Yes / No |
| Swollen Ankles                   | Yes / No | Chemotherapy              | Yes / No |                          |          |
| Stroke                           | Yes / No | Cold Sores/Fever Blisters | Yes / No |                          |          |

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

If yes, please list: \_\_\_\_\_

Women - 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/hygienist of any change in my health or medication.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 5. DENTAL HISTORY

In an effort to provide holistic dental care, please take the time to answer the following questions.

Why did you leave your last dentist? \_\_\_\_\_

What do you want in a dentist? \_\_\_\_\_

Have you had a bad dental experience? If so, please explain: \_\_\_\_\_

Are you deeply concerned about the finances required to return your mouth to excellent dental health? \_\_\_\_\_

When was your last dental appointment? \_\_\_\_\_

What did you have done? \_\_\_\_\_

What prompted you to seek dental care at this time? \_\_\_\_\_

What do you feel is the most important thing we can do for you at this time? \_\_\_\_\_

Do you play any contact sport that may require a mouth guard? If so, which sport? \_\_\_\_\_

How long since your last thorough examination / full mouth x-rays? \_\_\_\_\_

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? \_\_\_\_\_

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-coloured restoration instead? \_\_\_\_\_

Does food constantly get stuck between your teeth? \_\_\_\_\_

Are you dissatisfied with your teeth in any way? \_\_\_\_\_

If you could change one thing about your smile what would it be? \_\_\_\_\_

Are you dissatisfied with the way your teeth look? For example: Colour, Shape, Spaces etc. \_\_\_\_\_

Do you have any fillings that show in your front teeth? \_\_\_\_\_

Do any of your fillings show when you smile? \_\_\_\_\_

Have you ever had any teeth removed? \_\_\_\_\_

How long have these teeth been missing? \_\_\_\_\_

Are your teeth sensitive to?

Heat

Cold

Sweets

Biting / Pressure

Do your gums bleed when brushing? \_\_\_\_\_

Do you ever avoid any part of the mouth while brushing? \_\_\_\_\_

Have you been instructed regarding proper home care? \_\_\_\_\_

Do you have an unpleasant taste or odour in your mouth? \_\_\_\_\_

Do you frequently snack between meals or chew gum? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you use floss? \_\_\_\_\_

Do you want to learn to control dental disease and retain your teeth? \_\_\_\_\_

Do you snore? Yes / No

Do you suffer from OSA (Obstructive Sleep Apnoea)? Yes / No

**If yes,** have you been treated for OSA? Yes / No

Have you had a sleep study? Yes / No

Are you tired or lethargic during the day? Yes / No

**Jaw Joint Problems:**

**Do you have or have you had any of the following?** Please tick any that apply.

- |                                                          |                                                             |
|----------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Frequent Headaches              | <input type="checkbox"/> Facial pain                        |
| <input type="checkbox"/> Pain behind the eyes            | <input type="checkbox"/> Neck pain                          |
| <input type="checkbox"/> Jaw joint Pain                  | <input type="checkbox"/> Postural Problems                  |
| <input type="checkbox"/> Jaw joint Noise                 | <input type="checkbox"/> Numbness on the back of your hands |
| <input type="checkbox"/> Limited Opening of your mouth   | <input type="checkbox"/> Tingling fingers                   |
| <input type="checkbox"/> Ear Congestion                  | <input type="checkbox"/> Back pain                          |
| <input type="checkbox"/> Ringing in the Ears             | <input type="checkbox"/> Trauma to the jaw or face          |
| <input type="checkbox"/> Difficulty Swallowing           | <input type="checkbox"/> Trauma to the head or neck         |
| <input type="checkbox"/> Clenching / grinding your teeth |                                                             |

**If you have ticked any of the above questions, please elaborate:**

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## CONSENT

I understand that, to the best of my knowledge the questions on this form have been accurately answered. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or condition.

I authorise the dental staff to perform all necessary dental procedure that I may need with my informed consent. I also give permission to the doctor or his staff to use any photos he may take to be used for lecturing, publishing or educational purposes.

Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

To make your visit more comfortable, we have a selection of beverages, music and DVD's available to you. Please ask your treatment coordinator to supply you with our comprehensive list.

If you would like anything to make your visits with us more enjoyable, please don't hesitate to let our treatment coordinator know.

**Thank you**

**"Smile...**  
change your life"