

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? _____

