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NEW PATIENT FORM

At Verdant Dental we strive to provide you with the best possible care. To do this we need to collect personal information from you that includes contact details pertaining to your general health, both past and present. This information is necessary to ensure that the most appropriate treatment for your needs can be provided. Please be assured that this information is considered confidential and will be maintained in accordance with State and Federal Privacy Legislation.

Title: Given Name: Surname:

Preferred Name: D.O.B:

Home Address:

Suburb: Postcode:

Email Address: Mobile Phone:

Home Phone: Work Phone:

Please indicate your preferred method of contact for **appointment reminders**:

❑ Email ❑ SMS ❑ Mobile Phone ❑ Home Phone ❑ Work Phone

Private Health Fund (if any):

Policy Number: Reference Number:

Are you eligible for the Child Dental Benefits Schedule (CDBS)? ❑ Yes ❑ No ❑ Unsure

Medicare card number: Reference number:

In case of an **emergency**, who should we contact? Name:

Relationship: Phone number/s:

Who is your general medical practitioner? Name: Phone:

All accounts are to be settled at the end of each appointment.

If a carer/guardian/parent is responsible for settling the account, please give details:

Name: Relationship: Phone:

How did you find us?

❑ Practice website ❑ Google search ❑ Facebook

❑ Signage/walk by ❑ Mail drop ❑ Health insurance

❑ Family or friend - referred by _____

❑ Other (please specify): _____

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Any Dental Concerns that you might have?

❑ Pain in teeth or jaws	❑ Missing teeth	❑ Discoloured fillings or teeth
❑ Sensitive teeth	❑ Unsatisfactory denture	❑ Appearance of teeth
❑ Bleeding gums	❑ Worn teeth	❑ Bad breathe/taste in mouth
❑ Loose teeth	❑ Food catching between teeth	❑ Grinding or clenching teeth

Other concerns:

Reactions or complications following dental treatment in the past? ❑ Yes ❑ No

If yes, please specify details:

Allergies? ❑ Latex ❑ Penicillin ❑ Local anaesthetic ❑ Codeine

❑ Other (please specify): _____

Medical Conditions: Do you have, or have you ever had, any of the following?

❑ Heart Condition	❑ Diabetes	❑ Artificial joint (hip or knee)
❑ High Blood Pressure	❑ Excessive bleeding	❑ Osteoporosis or arthritis
❑ Stroke	❑ Tuberculosis	❑ Radiotherapy or chemotherapy
❑ Epilepsy	❑ AIDS/HIV	❑ Asthma or other lung disease
❑ Thyroid disease	❑ Hepatitis A, B, C, D, E	❑ Kidney disease
❑ Neurological disease	❑ Fainting or dizziness	❑ Anxiety or depression

Heart Conditions: If you have any, please tick all that apply:

❑ Heart attack ❑ Angina ❑ Valve problem ❑ Bypass ❑ Pacemaker ❑ Murmur ❑ Surgery

Do you normally require antibiotic cover before dental treatment? ❑ Yes ❑ No

Blood Thinning Medications : Are you taking any of the following?

❑ Warfarin (Coumadin/Marevan) ❑ Asprin (Astrix/Cartia) ❑ Plavix (Iscover) ❑ Xarelto

Are you taking any bisphosphonate medications, or medications for osteoporosis, multiple myeloma, metastatic cancer or Paget's disease? ❑ Yes ❑ No If yes, please specify: _____

Eg. Fosamax, Alendrol, Actonel, Didronel, Bonefos, Skelid, Aredia, Pamisol, Zometa

Medication list: Please list all tablets, capsules, injections, medications/drugs you're taking?

Do you **smoke**? ❑ Yes ❑ No Do you drink **alcohol**? ❑ Yes ❑ No

Do you think you may be **pregnant**? ❑ Yes ❑ No If so, how many weeks?

Is there anything else about your health we should know, or are you currently being treated by a doctor?

(Please specify):

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Terms of Acceptance and Privacy Statement

We thank you for taking the time to fill out this form and for giving us the opportunity to look after you. We will endeavour to provide you with the best care, skill and judgement you deserve. Please read the statement below and sign where indicated.

I acknowledge that the personal information collected from me by Verdant Dental is collected for the purpose of allowing Verdant Dental to provide dental services to me, and that if I do not provide relevant information, Verdant Dental may be unable to provide such services. I acknowledge that my information may be disclosed in part or full in accordance with State and Federal Privacy Legislation requirements, including disclosure to government and health organizations. I acknowledge that I am aware that I have rights to access information held by Verdant Dental in accordance with the National Privacy Principles. If you would like further information about how we use and protect your personal information, please ask our staff for the practice privacy policy.

I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee may be incurred if I fail to do so.

I have accurately completed this form to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk or compromise my treatment.

I hereby give my authority for any treatment agreed upon by me, to be carried out by the dental practitioners, and assume full financial responsibility for said treatment.

Patient Signature: _____ (parent or guardian to sign if patient is a minor)

Print Name: _____ Date: _____

Checked by: _____ (staff member signature)

Print Name: _____ Date: _____