CONFIDENTIAL - SURGERY ONLY

NEW PATIENT FORM

AVONDALE DENTAL
CREATORS OF GREAT SMILES

Thank you for joining us at Avondale Dental, welcome to our practice where patient care is the essence of our practice. We provide professional patient care where your needs are paramount. Our aim is to work with you to create a brilliant smile and a healthy mouth. Please take a few moments to complete this confidential new patient form. If you have any questions or need assistance to complete this form please let us know.

Please print clearly – thank you

Please tick one ○ Mr ○ Mrs ○ Miss ○ Ms ○ Dr ○ Other _____

First name _____ **Middle Name** _____ **Surname** _____

Date of birth _____ / _____ / _____

Address Number & Street _____

Suburb _____ City _____

Postal Address (if different from above) _____

Telephone Home (0 __) _____ Work: (0 __) _____ Mobile: (0 __) _____

Email _____

Who referred you to Avondale Dental? _____

For contact reasons please provide a contact (eg: your partner or spouse's name)

_____

Occupation _____

TO HELP US TO PROVIDE YOU WITH THE BEST POSSIBLE CARE, PLEASE TAKE A MOMENT TO ANSWER THE FOLLOWING QUESTIONS

1. What is the reason for your visit to Avondale Dental today?

_____

2. Please provide us with the last time you visited a dentist and, if you recall the name of the dentist or practice.

_____

3. How often do you go to the dentist?

_____

4. How would you best describe visiting the dentist? Please tick one or make a comment.

○ I do not get nervous or anxious Comment
○ I am a little nervous or anxious
○ I am very nervous and anxious

5. Is it important to you to keep your teeth for life? Tick one ○ Yes ○ No

Comment _____

P.T.O.

6. What is your general opinion about your teeth and mouth?

7. To ensure the best possible care, could you please note here if you have or suffer from any of the following:

Bleeding gums Sensitive teeth Frequent headaches or neck pain Pain when chewing
Clicking or pain in the jaw Clenching or grinding teeth

Comment

To assist us to provide you with excellent treatment, please provide our surgery with the following information

Medical History

1. What is your current Doctor's name Suburb

2. Have you experienced any of the following health issues? (please tick if the condition applies to you)

Heart problems
Bleeding disorders
Rheumatic fever
HIV infection
Digestive problems i.e. ulcers
Joint replacement (hip, knee etc)
Have you had a recent hospital visit/stay
Blood pressure
Diabetes
Hepatitis
Arthritis
Kidney problems
Problems with your lungs i.e. asthma, bronchitis

To ensure we understand your needs and can provide the best patient care, if you have ticked any of the above medical conditions, please take a moment to provide us with some details:

3. Do you have any allergies or are you allergic to anything? Tick one Yes No

If yes, please provide brief details

4. Are you currently taking any medication? Tick one Yes No

If yes, please provide brief details

5. Are you pregnant? Tick one Yes No If yes, how many months pregnant are you?

6. Have you ever had a serious illness? Tick one Yes No

If yes, please provide brief details

General Practice Information/Terms and Conditions do apply, please ask us for details. Please let our team know if you have any medical changes.

Our policy is to receive payment at the end of each visit. As all accounts are to be settled prior to leaving the surgery, any non-payment of treatments will incur additional fees and any cost related to debt collection.

By signing this two page New Patient Form you accept Avondale Dental terms and conditions and agree that you have provided correct information to Avondale Dental.

Signature **Name** **Date** / /