HORNE STREET DENTAL GROUP
NEW PATIENT INFORMATION SHEET

Do you require assistance in filling out this form? □ Yes □ No
If yes, please let reception know and they will try their best to accommodate you.

Patient Surname:……. Miss/ Mrs/ Ms/ Mr/ Master

Given Name:……...Patients D.O.B:……..……...

Living Address:…….

Suburb……..Post code:…….

Postal Address: (if different from above)

……...

E-Mail Address:……@……

Occupation:……...

Home Phone:……Work Phone:…….Mobile Phone……

Next of Kin:……..

Address & Phone of Next of Kin:……..……

Person Responsible for Fees: (FULL NAME)……..

How did you find out about this practice? (PLEASE TICK)

Friend/ Relative…….Name of person who referred you:…….

Local Directories…….Yellow Pages…….Another Surgery…….White Pages…….Walk In…….

MEDICAL HISTORY: Do you suffer from any of the following? Please indicate:

	YES	NO		YES	NO
BLOOD PRESSURE	□	□	DIABETES (TYPE)	□	□
CANCER	□	□	THYROID PROBLEMS	□	□
HEART PROBLEMS	□	□	ARTIFICIAL JOINTS	□	□
RHEUMATIC FEVER	□	□	ASTHMA	□	□
EPILEPSY	□	□	SLEEP DISORDER	□	□
KIDNEY OR LIVER DISEASE	□	□	OSTEOPOROSIS	□	□
HEPATITIS (SPECIFY)/HIV	□	□	EXCESSIVE BLEEDING	□	□
EXCESSIVE BRUISING	□	□	ULCERS (STOMACH)	□	□
SINUS TROUBLE	□	□	CIRCULATORY PROBLEMS	□	□
TUMOUR HISTORY	□	□	ALLERGIES TO LATEX	□	□
ALLERGIES TO ANAESTHETICS	□	□	ALLERGIES TO PENICILLIN	□	□
ALLERGIES TO MEDICATIONS	□	□	RADIATION TREATMENT	□	□
ANAEMIA/BLOOD DISORDERS	□	□			

List any other previous illnesses……..…….

Do you currently take drugs, medicines or tablets (IF YES PLEASE LIST)……..

…….

Are you of Aboriginal, Torres Strait Islander descent? □ Yes □ No

Are you pregnant? (IF YES PLEASE WRITE DUE DATE)……..
YES□…. NO□

Please turn over page

Have you had any of the following?

	YES		YES
Does your jaw click or hurt?	☐	Do you smoke?	☐
Do you feel you grind your teeth?	☐	Do you think you have occasional bad breath?	☐
Have you ever had orthodontic treatment?	☐	Do your gums ever bleed when you brush your teeth?	☐
Do you wear a night guard?	☐	Do you experience sensitivity with hot/cold?	☐
Have you ever had gum disease?	☐	Does floss ever tear between your teeth?	☐
Have you ever had your bite adjusted?	☐	Does food get jammed between your teeth?	☐
Do you bite your lips or cheek often?	☐		
Do your teeth ever hurt when you bite hard?	☐		

Name of your regular medical GP:……...

Address:…….

Phone:……

How long since your last dental appointment?……...

How often do you have dental examinations?……..

Previous dental x-rays were taken: ☐ less than a year ago ☐ longer than a year ago

Do you have any private health insurance? ……YES☐…. NO☐

Welcome and thank you for attending our practice.
Consent for treatment:
I herby authorise the dentist or designated team member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand it is policy to make full payment of account on day of treatment for all patients unless prior arrangements have been made before the day of your appointment. Any accounts referred to a collection agency or solicitor will have all legal costs and commissions added to the amount due.
I authorise that this data may be viewed by team members of the dental practice.

Patient Signature:……DATE:……...

Parent/ responsible party's signature:……

Relationship to patient:……..