# New Patient Details form

UNIVERSAL SMILES DENTAL

Title Dr / Mr / Mrs / Miss / Ms/ Other

Surname _____ First name _____ Date of birth ___/___/ _____

Preferred name _____ Your occupation _____

Home address _____

_____ Postcode _____

Postal address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

Email _____

Health fund for dental cover _____ Membership No. _____ Patient ID. _____

Medicare Card No. _____ Patient ID. _____ Vet Affairs Card No. _____

Emergency contact _____ Relationship to patient _____ Contact No. _____

Medical Practitioner _____ Contact No. _____

**Person responsible for account (must be completed if patient under 16, if same as above please tick here ☐)**

Name _____ Relationship to patient _____

Address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

If third party, insurance company/employer responsible for account _____

---

## Medical Questions – Private and Confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

**Past/Current medical conditions:** (please circle)

Are you receiving any medical treatment at present? YES / NO Details _____

Have you had any serious or long standing illness? YES / NO Details _____

Have you ever been hospitalised? YES / NO Details _____

Are you currently pregnant or breastfeeding? YES / NO Due date if pregnant: _____

Do you or have you ever smoked? YES / NO How many per day? _____

Do you drink alcohol? YES / NO Amount per day or week? _____

Have you ever had or are you currently receiving treatment for cancer? YES / NO
Details _____

Are you allergic to any medications/tablets/antibiotics or other? YES / NO Details _____

_____

**Current medications** (prescription, over the counter, herbal) _____

_____

UNIVERSAL SMILES DENTAL

**Please indicate if you have EVER had any of the following:**

| | | | |
|---|---|---|---|
| Any heart complaint / treatment | YES / NO | Tuberculosis | YES / NO |
| Rheumatic fever or heart valve surgery | YES / NO | Any nervous system disorder | YES / NO |
| High or low blood pressure | YES / NO | Gastric ulcer / digestive conditions | YES / NO |
| Blood disorders | YES / NO | Asthma / bronchitis / lung conditions | YES / NO |
| Anti-coagulant therapy | YES / NO | Radiation therapy / chemotherapy | YES / NO |
| Joint replacement surgery | YES / NO | Thyroid disease | YES / NO |
| Osteoporosis or bone disease | YES / NO | Hepatitis A,B or C | YES / NO |
| Epilepsy | YES / NO | Jaundice or other liver diseases | YES / NO |
| Diabetes | YES / NO | Transplanted organ or bone marrow | YES / NO |
| HIV or other blood borne viruses | YES / NO | Arthritis | YES / NO |
| Steroid therapy | YES / NO | Depression / anxiety | YES / NO |
| Sinus trouble | YES / NO | Kidney disease | YES / NO |
| Stroke | YES / NO | Bisphosphonate medications | YES / NO |

## Dental History – Private and Confidential

When was your last dental examination and clean? _____

Are you currently experiencing pain or a specific dental problem? YES / NO

Details _____

Are you nervous, anxious or ever had a bad experience at a dental visit? YES / NO

Details _____

Are you happy with the appearance of your teeth and smile? YES / NO

Details _____

Do you have bleeding gums or have you ever been diagnosed with or treated for gum disease? YES / NO

How frequently do you brush your teeth? ONCE A DAY / TWICE A DAY / Other _____

How frequently do you floss or use brushes to clean between your teeth? _____

Is there anything you would like to talk to your dentist about that you are not comfortable writing on this form? YES / NO

**Would you like to discuss or find out more about any of the following:** (please circle)

Replacement of missing teeth  Cosmetic appearance  Removal of wisdom teeth  Crowns  Veneers

Tooth whitening  Bad breath  Bleeding gums  Tooth grinding / Clenching  Root canal treatment

Replacement of silver (mercury) fillings  Dentures  Implants  Orthodontics

I agree that the above is a true and accurate record. I understand that this Universal Smiles Dental centre requires payment on the day of treatment. Any expenses, costs or disbursements incurred by the Universal Smiles Dental centre in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a non-refundable deposit requirement prior to future appointments being scheduled. I have read and agree with the privacy statement provided to me.

**PLEASE NOTE:** This form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

✗ Signature _____ Date ____ / ____ / _____