NEW MILLENNIUM DENTAL

NEW PATIENT HISTORY FORM

TITLE Mr/Mrs/Miss/Ms/Dr/Other

Name_________Preferred Name_________Surname___________Date of birth_________

ADDRESS: Street ____

Suburb/Town _____________ State _____ Post Code______ E-mail:__________________

Home Phone Number ______________Mobile ______________ Work _______________

How do you prefer to be contacted? Mobile / SMS /Home Phone/ E-mail_

Do you have Private Health Insurance? Yes / No Please Specify ______________________

If yes, please specify the Health Fund you are with and your patient ID No (i.e. 01)

Medicare Card No_____________________Ref. No________Expiry Date______________

Vet Affairs Gold / White (Please circle) **Vet Affairs Card No**:___________**Expiry Date_______**

Emergency Contact ______________________ Contact number______________________

How did you find out about our practice? Referred by existing patient *Who*?_______________

Referred by staff *Who*?________Yellow pages__ Yellow Pages Online__ Google__ Internet __ Passing By? Other___________

Are you happy with the colour and appearance of your teeth? Yes / No

Do you have pain or clicking in your jaw joints? Yes / No

MEDICAL HISTORY QUESTIONNAIRE

How do you rate your general health? □ Excellent □ Good □ Fair □ Poor

Name of your General Practitioner _________________ Contact number ______________

□ Heart Problems or Heart Operations □ High Blood Pressure □ Rheumatic Fever □ Heart valve / prosthetic valves □ Cardiac Pacemaker □ Joint replacement □ Lung Problems eg Asthman, Tuberculosis □ Kidney Problems □ Liver Problems □ Bleeding Problems / Blood disorders □ Thyroid Problems □ Epilepsy □ Arthritis	□ Osteoporosis □ Taking Fosamax, Actonel, Boniva, other medications affecting bone □ Infectious Diseases □ HIV / AIDS □ Radiation □ Chemotherapy □ Organ Transplant □ Bone Marrow Transplant □ Steroid Therapy □ Eating Disorders □ Are you or could you be pregnant □ Diabetes
□ Are you taking any medications? Please specify	□ Do you have any allergies? Please specify

DENTAL HISTORY

How long has it been since your last dental check-up? ☐6 months ☐1 Year ☐2 Years ☐3Years ☐Longer

☐ Toothache	☐ Missing Teeth	☐ Facial Pain
☐ Sensitive Teeth	☐ Ill-fitting Denture	☐ Jaw Joint Pain
☐ Bleeding Gums	☐ Rapidly Decaying Teeth	☐ Grinding Teeth
☐ Receding Gums	☐ Cavity	☐ Difficulty Chewing
☐ Loose Teeth	☐ Lost Filling	☐ Discoloured teeth
☐ Bad Breath	☐ Worn Teeth	☐ Bad Breath
☐ Dry Mouth	☐ Broken Teeth	☐ Do you smoke?

SIGNATURE ___________________________________ DATE _______/_____/_______

PATIENT REFERRAL PROGRAM

It gives us great pleasure that many of our patients value our services enough to refer us their family, friends and colleagues. We greatly appreciate this compliment & would like to reward these patients with more than a simple "thank you".