Mentone Family Dentist

NEW PATIENT FORM

PERSONAL INFORMATION

Full Name: _____

Date of Birth: ___/___/___ **Gender :** ☐ Male ☐ Female ☐ Non- Binary

Street Address: _____ **State:** _____ **Post Code:** _____

Primary Phone: _____ **Secondary Phone:** _____

Email: _____

Preferred Contact method: _____ **Occupation:** _____

Do you have Health Insurance Extras? ☐ Yes ☐ No **If yes, please fill out below.**

Name of Fund: _____ **Membership Number:** _____ **Reference Number:** _____

Is patient under 18? ☐ Yes ☐ No **If yes, please fill out below.**

Parent/Guardian's Name: _____

Are they eligible for the CDBS program? ☐ Yes ☐ No ☐ Don't know

Medicare Card Number: _____ **Reference Number:** _____

EMERGENCY CONTACT DETAILS

Contact Name: _____ **Relationship:** _____

Mobile Number: _____ **Home/work Number:** _____

Address: _____

DENTAL HISTORY

Date of last dental visit: ___/___/___ **Type of Toothbrush:** ☐ Manual ☐ Electric

Reason for changing dentist? (if applicable): _____

Type of Tooth Paste: ☐ Flouride ☐ Sensitive ☐ Whitening ☐ Other: _____

How many times do you brush your teeth per day? _____

How many times do you floss per day? _____ **How often do you use mouth wash?** _____

Do you use any Dental Appliances (e.g. retainers, night guards, braces)? _____

mentonefamilydentist@gmail.com
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www.metonefamilydentist.com.au

THANK YOU

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DENTAL HISTORY

Please tick those that apply to you.

- ☐ **Have had orthodontic treatment**
- ☐ **Recent dental pain, swelling or bleeding**
- ☐ **History of root canal treatment**
- ☐ **History of periodontal treatment**
- ☐ **Loud snoring**
- ☐ **People have noticed you stop breathing during sleep**
- ☐ **Daytime drowsiness and fatigue**
- ☐ **History of Sleep Apnea or use of a CPAP Machine**
- ☐ **Clenching Jaw or Grinding Teeth**
- ☐ **You've noticed a worn, chipped or cracked tooth**
- ☐ **You experience head aches or jaw pain upon waking**

Do you consume sugary food and drinks regularly? ☐ Yes ☐ No How regularly? _____

Do you consume alcohol? ☐ Yes ☐ No How regularly? _____

Do you smoke? ☐ Yes ☐ No How regularly? _____

Do you have oral piercings? ☐ Yes ☐ No If yes, describe location _____

Please provide any information or dental conceners you'd like to share with us: _____

_____

MEDICAL HISTORY

General Practitioner's name: _____

Date of last physical examination: ___/___/___ **GP Clinic's name:** _____

Have you had serious illness, injury or been hospitalised in the past 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any prescription or over the counter medication(s)? ☐ Yes ☐ No

If so please fill out the table below:

Medication	Purpose	Dosage	For how long?

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MEDICAL HISTORY

Please tick conditions/illness that apply to you.

- ☐ **Asthma**
- ☐ **Anxiety/depression**
- ☐ **High blood pressure**
- ☐ **Low blood pressure**
- ☐ **Rheumatoid arthritis**
- ☐ **Diabetes**
- ☐ **Hepatitis**
- ☐ **Joint replacement surgery** Which joint? _____
- ☐ **Blood disorders**
- ☐ **Thyroid disease**
- ☐ **Cancer**
- ☐ **Epilepsy/Seizures**
- ☐ **Rheumatic fever**
- ☐ **Bronchitis/lung conditions**
- ☐ **Lupus (SLE)/Polymyalgia**
- ☐ **Heart condition/cardiac surgery/pacemaker**
- ☐ **Heart valve replacement**
- ☐ **Jaundice or liver disease.**
- ☐ **Excessive bruising or bleeding**
- ☐ **Osteoporosis/low bone density**
- ☐ **Nervous system disorder**
- ☐ **Jaw, neck or shoulder injury or pain**
- ☐ **Transplanted organ/bone marrow/stem cells**

Are you or is there a chance you are pregnant? ☐ Yes ☐ No If yes, due date: ___/___/___

Please provide any information on conditions not listed above: _____

_____

Please list any and all allergies below.

_____

_____

_____

ACKNOWLEDGMENT AND CONSENT

I acknowledge that the information provided is accurate to the best of my knowledge.

I consent to the dental examination and any necessary treatments, as deemed appropriate by the dental team.

I understand that the dental team may use the information provided for diagnostic and treatment planning purposes.

Patient/guardian's Signature: _____ **Date:** ___/___/___

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