Western Dental Care

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New Patient Details

Title *(circle answer)*: Mr | Mrs | Miss | Ms | Master

Surname: Given Name/s: D.O.B:

Address: Suburb: P/Code:

Contact No.'s: Mobile: Work no.: Health Fund:

Email: Occupation: Company:

Medical Doctors' Name and Practice:

Emergency Contact Name, Number & Relationship: _____

Do you have a Voucher *(circle answer)*? Child Benefit Dental Scheme | Government Voucher | Veterans Voucher

How did you hear about our practice *(circle answer)*? Passing by | Referred | Ad

Reason for presenting to the surgery *(circle answer)*: Consultation | Pain | Other

Have you ever had a difficult tooth extraction/ or experienced prolonged bleeding *(circle answer)*: Y / N

Medical History

Have you ever stayed in the Hospital, had an operation or a general anesthetic?	Y / N	Is the patient suffering from recent progressive dementia (or less than 12 months duration) the cause of which has not been diagnosed?	Y / N
Have either or any member of the immediate family had a reaction of any nature to a general anesthetic?	Y / N	Do you have family history of two or more first degree relatives with Creutzfeldt-Jakob Disease or other progressive neurological disorder?	Y / N
Have you ever had any serious problems after dental treatment?	Y / N	Do you have Diabetes?	Y / N
Have you ever had any type of heart disease, heart murmur, high blood pressure or rheumatic fever? Do you have a pacemaker?	Y / N	Have you ever had kidney problems?	Y / N
		Do you have any joint problems, arthritis or history of joint replacement surgery?	Y / N
Have you ever had heart valve or open heart surgery? Have you had any recent stent placed / operation?	Y / N	Do you have any other medical or disability problems? *(If yes, please list on the next page)*	Y / N
Have you ever had a stroke, fits or epilepsy?	Y / N	Are you currently taking any medications, or have taken any in the last 3 months. In particular for osteoporosis? And are you taking blood thinning tablets? *(If yes, please list on the next page)*	Y / N
Are you undertaking psychiatric treatment?	Y / N		
Have you ever had tuberculosis, asthma or any other lung disease?	Y / N	Are you allergic to any tablets, medicines or latex? *(If yes, please list on the next page)*	Y / N
Do you smoke?	Y / N		
Have you ever had hepatitis or any other liver disease?	Y / N	Do you require an interpreter? (*If yes, patient must provide their own interpreter)*	Y / N
Are you pregnant?	Y / N		

PATIENT FILE NO.: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____

Current Medications:

TODAYS DATE	MEDICATION NAME	STRENGTH	NO. TIMES A DAY	LAST TAKEN

Medical problems or/ other:

_____

_____

_____

_____

_____

_____

_____

Patient Signature: **Date:** _____

Guardian Signature (if patient younger than 18 years old): **Date:** _____

Dentist Signature: **Date:** _____