DentaGlow
COMMUNITY, QUALITY, AFFORDABLE

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NEW PATIENT DENTAL HISTORY FORM

Please note that all information on this medical form will remain strictly confidential. Please complete in **CAPITAL LETTERS**

Surname		**First Name**	
Date of Birth	/ /	Occupation	
Phone (H)		Address:	
Phone (W)			
Mobile			
Email address			
Emergency Contact Name		Do you have health insurance	☐ **YES** ☐ **NO**
Phone No		Insurance Name	
		Insurance No	

To complete if the patient is under 18 years old

Guardian Name & Phone No		
Medicare Card No:		Ref No
Are you eligible for any of the following scheme		
☐ **Child Dental Benefit Scheme MEDICARE**		
☐ **DVA**	DVA Card No	
☐ **Government Voucher**		

Referral Information (MUST BE FILLED)

☐Internet/website ☐Yellow Pages ☐Shop A Docket ☐Flyers ☐Newspaper
☐Walked Past ☐Facebook ☐Freebies Centro ☐Billboard Sign ☐Google Search
☐Child Care Centre ☐ OZ Little Directory ☐Stall ☐Radio ☐TV Display/Cinema
☐Family/Friends: **NAME PLZ**_____ ☐Other_____

MEDICAL HSITORY

Name of your GP		GP Phone	
Your doctor's address			
Current Medication Plz specify			

Have you ever had any of the following? Please tick those that apply:

☐Anemia ☐Fainting ☐Pacemaker
☐Artificial Joints ☐Glaucoma ☐Radiation Therapy
☐Asthma ☐Heart Disease ☐Respiratory Problems
☐Blood Disease ☐Heart Murmur ☐Rheumatic Fever
☐Cancer ☐Hepatitis A, B, C ☐Sinus Problems
☐Dizziness ☐High Blood Pressure ☐Stroke
☐Epilepsy ☐Kidney Disease ☐Tuberculosis
☐Excessive Bleeding ☐Liver Disease ☐Bleeding Problems
☐Diabetes ☐HIV/AIDS ☐Psychological Disorders
Are you pregnant? ☐Allergy If Yes Please Specify:_____
If yes, how many months?

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DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (Please tick as many as it applies)

☐Sensitivity to hot or cold
☐Staining of your teeth
☐Bleeding Gums
☐Head/Neck Ache
☐Food Trapping between your teeth
☐Discolored filling
☐Bad Breath
☐ Grinding or cleaning of your teeth
☐Clicking/pain in jaw joints
☐Roughness of existing filling
☐Sensitivity when eating

Are you concerned with: (Please tick as many as it applies)

☐Existing Crown, bridges or dentures
☐Missing teeth
☐Crooked tooth
☐Tooth clean techniques (e.g. brushing/flossing)
☐ Your Smile
☐ Silver Filling
☐Gaps between your teeth
☐Discoloration of your teeth
☐Previous Dental treatment
☐Ability to eat

What was the main purpose of your visit today?

_____

How long since your last dental visit?

_____

Does dental treatment make you nervous?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agree to be necessary or advisable, including the use of local anesthetics as indicated and I will assume responsibility for the fees associated with those procedures
- I understand that the practice requires as minimum 24 hours' notice if I need to cancel my schedule appointment and that a cancellation fee of **$75.00** could be incurred if I fail to do so
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures and publication that the dentist may author.
- I am aware that payment is required on the day of treatment.

Patient's (or parent) Signature:_____ **Date of Signature:**_____

Parent Name if Patient is Minor:_____