Essendon Dental Group
167 Buckley Street
Essendon Vic 3040
tel (03) 9337 5589
fax (03) 9331 2358
reception@essendondg.com.au

New Patient Details

Please complete this form as fully as possible.

All information collected is used to ensure that your health and safety is maintained and that the best treatment possible is provided. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available on request

Surname: _____ Given Name(s): _____

Preferred Name: _____ Title:(Mr/Mrs/Ms/Dr) Date of Birth ____/____/____

Address: _____

Home Phone: _____ Mobile: _____

Email: _____

How did you find out about Essendon Dental Group? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Name of person responsible for fees (parent/guardian/carer): _____

Address (if different to above): _____

PLEASE NOTE Full payment of fees is due on the day of service unless discussed otherwise prior

Do you have private health insurance: YES/NO Name of fund: _____

Are you eligible for the Child Dental Benefits Schedule (CDBS): YES/NO

Preferred method for appointment reminders and other communication

☐ SMS ☐ Email ☐ Letter ☐ Phone

Medical History

Medical Doctor: _____ Phone: _____

Address: _____

Have you ever had problems with dental treatment? _____ (please discuss with dentist)

Female patients, are you pregnant? If so, how many weeks _____

Do you smoke? YES/NO If so, how many per day _____

CONTINUED OVERLEAF...

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To the best of your knowledge do you have or have you suffered from the following? If possible please provide approximate date of diagnosis.

	YES	NO		YES	NO
Asthma, chest or breathing problems	☐	☐	Diabetes	☐	☐
Heart ailment (surgery/rheumatic fever)	☐	☐	High blood pressure	☐	☐
Excessive bleeding or blood disorder	☐	☐	Epilepsy	☐	☐
Bone disorder/diseases (osteoporosis)	☐	☐	Back or neck problems	☐	☐
Thyroid problems	☐	☐	Stomach or bowel problems (e.g. ulcer)	☐	☐
Kidney disease	☐	☐	Cancer, if so where _____	☐	☐
Hepatitis	☐	☐	AIDS/HIV	☐	☐

Do you have: an artificial hip, heart valve or other prosthetic implants? ☐ ☐

Please state any other previous illnesses or major surgery in the last 5 years: _____

Do you have any allergies? (Please List e.g. penicillin, latex): _____

_____

Are you taking any drugs, medicines or tablets? (Please List; alternatively a list may be attached):

_____

_____

_____

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, x-rays or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and I consent to this. I give my permission for the practice to use the above contact details to send me appointment and check-up reminders.

Signed _____ Date _____

FOR FUTURE MEDICAL UPDATES:

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____