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Sydney CBD Dental

…Making the City Smile

NEW PATIENT FORM

At Sydney CBD Dental we strive to provide you with the highest possible care. To do this we need to collect personal information from you. Without this information it is difficult for your Dentist or Hygienist to plan your individual care.

All information provided today is kept in accordance with the Privacy Act 1988.

Surname:	**Given Name**:	**Title:**
Preferred Name:	**Date of Birth:**	
Address:	**Suburb**:	**Postcode**:
Home Phone:	**Mobile:**	**Work:**
Email address:		
Name of Private Health Fund:	**Member No:**	**Position No:**
Occupation:		
Emergency Contact		
Name:	**Relationship:**	**Phone:**

Reminder System:

At Sydney CBD Dental we remind our patients of their appointments. If you would like us to do this please indicate the preferred means of contact.

☐ SMS ☐ email ☐ mobile ☐ home ☐ work

How did you hear about us?

☐ Referred by friend/family/colleague _____

☐ Google ☐ BUPA Website ☐ Health Fund

☐ Billboard ☐ Corporate Dental Program ☐ BUPA Retail Store

☐ Other**:** _____

Dental History

Time since last dental appointment?

□ Less than 6 months □ 6-12 months □ More than 12 months

Please tick any dental concerns you have? (please tick)

□ Toothache/sensitivity	□ Dry mouth	□ Grinding/clenching teeth
□ Bleeding gums	□ Missing teeth	□ Joint pain/clicking
□ Cavities/broken teeth	□ Wisdom teeth	□ Appearance of teeth
□ Lost filling	□ Bad breath	□ Would you like whiter teeth?

Medical History

Have you had or are you suffering from any of these? (please tick)

□ Heart Conditions	□ Asthma
□ High/Low blood pressure	□ Osteoporosis
□ Diabetes	□ Excessive or prolonged bleeding
□ Hepatitis	□ Radiation or chemotherapy
□ Rheumatic Fever	□ Eating disorder
□ Arthritis	□ Smoker
□ Sleep Apnoea	□ Pregnant or family planning
□ Gastric problems	□ Other (specify) _____

Allergies? (please specify eg anaesthetic, latex, penicillin, etc)

Current medications?

Name of GP _____ Contact Details _____

We do not offer credit for treatment at Sydney CBD Dental however we do recommend a number of agencies that may offer financial assistance. Please ask our Friendly team member.

We require 48 hour cancellation notice. All appointments not attended will be charged at a rate of $75.00

I have completed this questionnaire to the best of my knowledge. I hereby give my consent for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for all treatment.

Patient signature: _____ Date: _____

(Parent or Guardian to sign if patient is a minor)