# NEW PATIENT HISTORY FORM

Today's Date:_____

Title (Mr/Mrs/Miss/Ms/Dr/Other): _____

First Name: _____

Surname: _____

Contact Number: _____

Email: _____

Address: _____

_____

Postcode: _____ State:_____

Date of Birth:_____

Gender: _____

Are you of Aboriginal or Torres Strait Islander descent?

YES ☐ / NO ☐

Do you require an interpreter? YES ☐ / NO ☐

Occupation: _____

Emergency Contact Name: _____

Emergency Contact Number:_____

Relationship: _____

Name of person responsible for payment of accounts:

_____

Private Health Fund / DVA Name (if applicable):

_____

Are you eligible for the Child Dental Benefits Scheme?

YES ☐ / NO ☐ If Yes please provide your:

Medicare Number: _____

Reference Number: _____

## DENTAL HISTORY

What is the purpose of your visit today?

_____

How long since your last **DENTAL VISIT**?

| | |
|---|---|
| Less than 1 year ago | ☐ |
| Approx. 1 year ago | ☐ |
| More than 2 years | ☐ |

When were your last **DENTAL X-RAYS** taken?

| | |
|---|---|
| Less than 1 year ago | ☐ |
| More than 1 year ago | ☐ |
| Don't Remember | ☐ |

What is your home oral hygiene routine?
(e.g. Electric or manual toothbrush, brush 2 times a day, flossing)

_____

_____

### ARE ANY TEETH SENSITIVE TO:

| | |
|---|---|
| Hot or cold? | ☐ |
| Sweet tastes? | ☐ |
| Biting or chewing? | ☐ |

### HAVE YOU EXPERIENCED:

| | |
|---|---|
| Clicking or popping of the jaw? | ☐ |
| Ear, face, jaw pain? | ☐ |
| Difficulty opening or closing your mouth? | ☐ |
| Difficulty chewing? | ☐ |
| Cold sores or blisters around your mouth? | ☐ |
| Loose teeth or a change in your bite? | ☐ |
| Food trapping between your teeth? | ☐ |
| Bleeding gums (when cleaning your teeth)? | ☐ |

### DO YOU:

| | |
|---|---|
| Grind your teeth? | ☐ |
| Wear a dental night guard? | ☐ |
| Have aching jaws, especially in the mornings? | ☐ |
| Have a dry mouth? | ☐ |
| Suffer from occasional bad breath? | ☐ |
| Have a history of gum disease or tooth loss? | ☐ |
| Bite your cheeks, lips or tongue often? | ☐ |

### HAVE YOU EVER HAD:

| | |
|---|---|
| Orthodontic treatment? | ☐ |
| Periodontal (gum) treatment? | ☐ |
| Your bite adjusted? | ☐ |
| Any teeth removed? | ☐ |
| Oral surgery? | ☐ |
| Sore gums? | ☐ |
| A serious injury to your mouth or head? | ☐ |
| If yes, please describe the injury: | |

### ARE YOU:

| | |
|---|---|
| A current smoker/vaper? | ☐ |
| If yes how many per day? | |
| A past smoker/vaper? | ☐ |
| If so when did you quit? | |
| A contact sport participant? | ☐ |
| Pregnant? | ☐ |
| If yes, how many weeks? | |
| Breast Feeding? | ☐ |
| On any form of oral contraceptive? | ☐ |

# NEW PATIENT HISTORY FORM

## MEDICAL HISTORY

It is important to know details about your medical history as these could affect the success of your dental treatment and how your treating dental practitioner can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy.

Are you receiving any medical treatment at present?

YES ☐ / NO ☐

If yes, please provide details:_____

_____

Name of your medical practitioner/specialist:

_____

Surgery contact number:_____

Have you been hospitalised in the last 12 months?

YES ☐ / NO ☐

If yes, please list why: _____

_____

Are you taking any medication or supplements? (These can include herbal preparations, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants, etc.) We ask this so that your treating dental practitioner can take precautions to minimise risks and known negative interactions.

YES ☐ / NO ☐

If yes please list:

**PLEASE INDICATE IF YOU HAVE HAD OR ARE BEING TREATED FOR ANY OF THE FOLLOWING:**

| | |
|---|---|
| Heart Condition / Heart Surgery | ☐ |
| Mitral Valve Prolapse | ☐ |
| Heart Valve / Pacemaker | ☐ |
| Stroke | ☐ |
| Rheumatic Fever | ☐ |
| Polymyalgia | ☐ |
| Lupus (SLE) | ☐ |
| Diet (special/restricted) | ☐ |
| Digestive Problems | ☐ |
| Gastroesophageal Reflux | ☐ |
| Gastric Ulcers | ☐ |
| Circulatory Problems | ☐ |
| Blood Pressure (high/low) | ☐ |
| Kidney / Renal Disease | ☐ |
| Liver Problems / Jaundice | ☐ |
| Diabetes | ☐ |
| Thyroid Disease | ☐ |
| Emphysema | ☐ |
| Chronic Cough | ☐ |
| Tuberculosis | ☐ |
| Lung Condition | ☐ |
| Bronchitis | ☐ |

| | |
|---|---|
| Asthma | ☐ |
| Hay fever | ☐ |
| Sinus Trouble | ☐ |
| Allergies (medicine, antibiotics, pain relievers, anaesthetic, antibiotics, contact allergies) | ☐ |
| Latex sensitivity | ☐ |
| Snoring / Sleep Apnoea | ☐ |
| Hepatitis | ☐ |
| Blood Borne Virus (AIDS/HIV, Hep B/C) | ☐ |
| Blood Transfusion | ☐ |
| Blood or Bleeding Disorder | ☐ |
| Anaemia | ☐ |
| Bruise or Bleed Easily | ☐ |
| Leukaemia | ☐ |
| Cancer | ☐ |
| Tumour History | ☐ |
| Radiation / Chemotherapy | ☐ |
| Neurological Disorder | ☐ |
| Epilepsy or Seizures | ☐ |
| Fainting or Dizzy Spells | ☐ |
| Anxiety | ☐ |
| Depression | ☐ |
| Psychiatric Condition | ☐ |

| | |
|---|---|
| Osteoporosis | ☐ |
| Arthritis / Rheumatism | ☐ |
| Bone Disorder or Disease | ☐ |
| Knee Reconstruction | ☐ |
| Prosthetic Implant | ☐ |
| Artificial Joints (hip, knee) | ☐ |
| Jaw / Neck Injury or Pain | ☐ |
| Steroid Therapy | ☐ |
| Transplant (organ, marrow) | ☐ |
| Infectious Disease (any) | ☐ |
| Other | ☐ |
| If you have answered yes or other, please provide details: | |
| Any other relevant information: | |

# NEW PATIENT HISTORY FORM

## HOW DID YOU HEAR ABOUT THE CLINIC?

| | | | | | |
|---|---|---|---|---|---|
| Signage / Walk by | ☐ | Health Fund | ☐ | Radio Advertising | ☐ |
| Doctor / Dentist Referral | ☐ | Flyer / Leaflet | ☐ | Social Media | ☐ |
| Internet / Google Search | ☐ | School / Club/Sponsor | ☐ | Word of Mouth / Referral | ☐ |
| Business Directory | ☐ | Magazine or Print Media | ☐ | Other | ☐ |

## YOUR TREATMENT

Maven Dental Group Pty Ltd manages dental centres in Australia and provides dental practitioners with the administrative and non-dental services that those dental practitioners need to provide you with dental services. Normally, those dental practitioners are not our employees and, in providing dental services and doing other things, are operating their own independent businesses. Your treating dental practitioner is ultimately responsible for your care and you should address any queries or concerns that you have regarding your treatment to them.

## CONSENT FOR TREATMENT

1. I have answered all questions to the best of my knowledge. Should further information be required, you have my permission to contact my medical practitioner, who may release such information to you.

2. I consent to a dental practitioner or designated team member to take x-rays, study models, photographs and other diagnostic aides as deemed appropriate by a dental practitioner to make a thorough dental diagnosis.

3. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. I also understand that if for any reason recovery of funds is required, and costs involved will be at my expense. I understand that if I cancel an appointment within 24 hours of my appointment, I may be liable for payment of a cancellation fee.

Patient Name:_____ Date: _____

Patient Signature: _____ Parent/Guardian:_____

## WE RESPECT YOUR PRIVACY

**Please read this Privacy Collection Statement to see how we use your personal information.**

Maven Dental Group Pty Ltd collects your personal information for purposes related to (or in the case of sensitive information, directly related to) our functions or activities including facilitating the delivery of dental services to you by independent dental practitioners, informing you of services which may be relevant to you and to communicate with you. We may not be able to facilitate the delivery of health services to you if you do not provide this information. Your personal information may be disclosed to our related bodies corporate, dental practitioners and third-party services providers, which may include those located overseas.

*Please refer to our Privacy Policy which is available at reception and at mavendental.com.au/policy/privacy-policy/ for full details of how we handle your personal information.

**If you would like to:**
- Inform us that you do not wish to receive promotional material,
- Request access to or the correction of information we hold about you,
- Make a complaint about our treatment of your privacy,

**You can contact us on:**
privacy@mavendental.com.au OR mail to:
The Privacy Officer, Maven Dental Group Pty Ltd,
PO Box 5454, West End QLD 4101.

I acknowledge that I have read, understand and agree to my personal and sensitive information being handled in accordance with, Maven Dental Group's Privacy Collection Statement and Privacy Policy*.

Name:_____ Signature: _____ Date: _____