

# 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	<input type="checkbox"/>
Approx. 1 year ago	<input type="checkbox"/>
More than 2 years	<input type="checkbox"/>

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

Less than 1 year ago	<input type="checkbox"/>
More than 1 year ago	<input type="checkbox"/>
Don't Remember	<input type="checkbox"/>

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?	<input type="checkbox"/>
Sweet tastes?	<input type="checkbox"/>
Biting or chewing?	<input type="checkbox"/>

### HAVE YOU EXPERIENCED:

Clicking or popping of the jaw?	<input type="checkbox"/>
Ear, face, jaw pain?	<input type="checkbox"/>
Difficulty opening or closing your mouth?	<input type="checkbox"/>
Difficulty chewing?	<input type="checkbox"/>
Cold sores or blisters around your mouth?	<input type="checkbox"/>
Loose teeth or a change in your bite?	<input type="checkbox"/>
Food trapping between your teeth?	<input type="checkbox"/>
Bleeding gums (when cleaning your teeth)?	<input type="checkbox"/>

### DO YOU:

Grind your teeth?	<input type="checkbox"/>
Wear a dental night guard?	<input type="checkbox"/>
Have aching jaws, especially in the mornings?	<input type="checkbox"/>
Have a dry mouth?	<input type="checkbox"/>
Suffer from occasional bad breath?	<input type="checkbox"/>
Have a history of gum disease or tooth loss?	<input type="checkbox"/>
Bite your cheeks, lips or tongue often?	<input type="checkbox"/>

### HAVE YOU EVER HAD:

Orthodontic treatment?	<input type="checkbox"/>
Periodontal (gum) treatment?	<input type="checkbox"/>
Your bite adjusted?	<input type="checkbox"/>
Any teeth removed?	<input type="checkbox"/>
Oral surgery?	<input type="checkbox"/>
Sore gums?	<input type="checkbox"/>
A serious injury to your mouth or head?	<input type="checkbox"/>
If yes, please describe the injury:	

### ARE YOU:

A current smoker/vaper?	<input type="checkbox"/>
If yes how many per day?	
A past smoker/vaper?	<input type="checkbox"/>
If so when did you quit?	
A contact sport participant?	<input type="checkbox"/>
Pregnant?	<input type="checkbox"/>
If yes, how many weeks?	
Breast Feeding?	<input type="checkbox"/>
On any form of oral contraceptive?	<input type="checkbox"/>

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## 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 TICK IF YOU HAVE, OR HAVE HAD 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	

Hayfever	
Sinus Trouble	
Latex Sensitivity	
Allergies (medicine, antibiotics, pain relievers, anaesthetic, antibiotics, contact allergies)	
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	
Infectious Disease (any)	

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)	
A Disability	
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	
Doctor / Dentist Referral	
Internet / Google Search	
Business Directory	

Health Fund	
Flyer / Leaflet	
School / Club/Sponsor	
Magazine or Print Media	

Radio Advertising	
Social Media	
Word of Mouth / Referral	
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/](http://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: \_\_\_\_\_