BALGOWLAH DENTAL CLINIC

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8/470 Sydney Rd,
Balgowlah 2093 NSW

NEW PATIENT FORM

Personal Details

Title: ________________ Given Name: ________________________________ Surname: __________________________________

Date of Birth: ____/____/________ Phone: ____________________________ Email: _____________________________________

Address: ____________________________________Suburb: ___________________________ Postcode:_____________________

Emergency Contact: _________________________ Relationship: _________________ Phone: ______________________________

Do you have private health insurance that covers dental? ☐ No ☐ Yes - Name of fund: __________________________________

Please select your preferred method of communication for appointment reminders:

☐ Email ☐ SMS ☐ Phone Call

How did you find out about us?

☐ Referred by existing patient or member of practice - whom may we thank for the referral? ____________________________

☐ Social Media ☐ Google Maps ☐ Google Search

Other - Please Specify ____

Medical History

Please feel free to discuss any additional conditions or concerns with your dentist. Your health and well-being are our top priorities, and we are here to address any further issues you may have.

Do you have any allergies?: ☐ Yes ☐ No
Are you allergic to: ☐ Latex ☐ Penicillin ☐ Other:____

Please tick the corresponding box if you are being treated for, or if you have a history relating to any of the following conditions:

☐ Blood pressure
☐ Heart disease
☐ Stroke
☐ Cardiac pacemaker
☐ Hepatitis
☐ Sleep apnoea
☐ Asthma
☐ Diabetes
☐ Epilepsy
☐ Cancer/Tumours
☐ Radiation Therapy/Chemotherapy
☐ Infectious disease (e.g. CID, TB, STAPH)
☐ HIV/AIDS
☐ Migraines / headaches
☐ Kidney disease
☐ Liver disease
☐ Thyroid disease
☐ Lung disease/Tuberculosis
☐ Artificial joints i.e. Hip, Knee
☐ Rheumatic fever
☐ Blood disorder
☐ Excessive bleeding
☐ Stomach/bowel disorder
☐ Mental health issue
☐ Eating disorder
☐ Osteoporosis
☐ Smoking

☐ Other - Please specify: ____

Are you currently pregnant? ☐ No ☐ Yes > What is your estimated due date?: ______________________________

Are you currently taking any medications? ☐ No ☐ Yes > Please specify: ____

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Dental History and Conditions

Do you have concerns in the following areas?

- ▢ Receding gums/gum bleeding or disease
- ▢ Swelling, ulcers, lumps or cold sores
- ▢ Unpleasant breath
- ▢ Broken/chipped teeth
- ▢ Lost filling/crown
- ▢ Large fillings
- ▢ Discoloured teeth/fillings
- ▢ Unattractive smile
- ▢ Snoring/Mouth breathing
- ▢ Toothache
- ▢ Sensitivity to heat/cold or biting
- ▢ Missing teeth
- ▢ Wisdom teeth
- ▢ Dry mouth
- ▢ Sore or clicky jaw
- ▢ Facial pain
- ▢ Clenching/ Grinding
- ▢ Other: ________________________________

When did you last visit the dentist? ____

How do you feel when you come to the dentist? (please mark on the scale below)

|____|____|____|____|____|____|____|____|____|____|____|____|

Not Anxious — *Extreme Phobia*

Reason for anxiety: *(If applicable)*
▢ Bad experience ▢ Poor service in the past ▢ General Anxiety ▢ Prefer not to say
▢ Other: ________________________________

Balgowlah Dental Policy and Consent

Cancellation Policy:
We understand that you may need to reschedule or cancel your appointment. We appreciate as much notice as possible but a minimum of 48 hours is requested. Unfortunately, if you do not notify us within this time or fail to attend an appointment, a fee of $50 may be charged for a missed appointment.

Consent for Treatment:
I authorise the dentist or designated team member to take x-rays, study models, photographs and other diagnostic aids, agreed upon with myself, to make a thorough diagnosis. I authorise the dentist to perform treatment mutually agreed upon by me.
I agree to the use of local anaesthetic agents, sedatives and medications deemed necessary for my treatment following consultation with the dentist. I understand I can ask for a full list of any complications.
I agree to be responsible for all services rendered to myself or my dependents and understand that payment is due at the time the service is rendered.

▢ I authorise the use of anonymised photos for use in promotional material for Balgowlah Dental Clinic

Patient/Guardian's signature: ____ Date: ________________