



818 Dental
818 High Street
Armadale Victoria 3143
03 9509 1883
reception@818dental.com.au
www.818dental.com.au

NEW PATIENT DETAILS

PERSONAL DETAILS

Title _____ First Name _____ Surname _____

Preferred Name _____ Date of Birth _____

Address _____

Suburb _____ State _____ Postcode _____

Mobile _____ Home _____

Work _____ Occupation _____

Email _____

We confirm all of our patients' appointments, which method/s do you prefer? SMS Email Phone

How did you hear about our practice? _____

If you were referred by a patient, please provide their name

EMERGENCY CONTACT DETAILS

Contact Name _____

Contact Number _____ Relationship _____

PRIVATE HEALTH INSURANCE

Health Fund _____

Membership Number _____ (_____)

DENTAL HISTORY

What is the reason for your visit today? _____

When was your last appointment? _____

What treatment did you have done? _____

When did you last have x-rays? _____

Why did you decide to leave your previous dental clinic? _____

Are you happy with the appearance/colour of your teeth? _____

Please check (✓) if any of the following apply

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding | <input type="checkbox"/> Loose / Broken Fillings | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Clicking / Popping Jaw | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Dental Anxiety |

Are there any aspects of dentistry you would like to ask us about today? _____



818 Dental
818 High Street
Armadale Victoria 3143
03 9509 1883
reception@818dental.com.au
www.818dental.com.au

MEDICAL HISTORY

Medical Practitioner _____

Clinic Name _____ Clinic Phone _____

Have you ever been hospitalised? *If so, for what and when?*

Do you smoke? YES NO *If yes, how many a day?* _____

Ladies, are you pregnant? YES NO *If yes, which trimester?* _____

Please check (✓) if any of the following apply

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Condition/s | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis | |

Other _____

Are you currently taking any medications? *If yes, please list name + dosage*

Allergies

- | | | | | |
|--------------------------------------|----------------------------------|----------------------------------|--|--------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anaesthetic | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Foods | | | |

Other _____

Privacy Policy Act

This practice adheres to the ADA privacy policy. Records are only collected with the patient's written consent. These records are for use by 818 Dental only where relevant to our dental function and are kept confidential. Dental records are the property of 818 Dental. Patients can request a copy of their records to be sent to another health professional upon written consent. A processing/administration fee of \$50 may apply.

Cancellation/Broken Appointment Policy

Here at 818 Dental, we require 48-hour notice for changes to any appointments. This allows the practice time to fill the cancelled time slot and sufficient notice to offer other patients the opportunity to come in for an appointment. Broken appointments without 48-hour notice will incur a \$50 broken appointment fee which will be invoiced to your file and that fee will need to be paid before your next appointment. We understand circumstances do arise at short notice which is why the broken appointment fee will only be charged if we cannot fill the time slot allocated for you.

Payment is required the day of your appointment.

Patient Consent

I certify that I have read, understood and agree to the practice policies and procedure as outlined. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____ Date: _____