Dr Lother Poon BDSc (Melb 02') F.I.C.C.D.E (Ortho)
Dr Hemal Sanghvi BDSc (Melb)
Dr Aida Ravari BDSc Hons (Melb)
Bei Bei Shen Hygiene Therapist
Sonja Tadic Practice manager

SEDDON DENTAL
Gentle Dentistry since 1999

www.seddondental.com.au

NEW PATIENT FORM

PATIENT INFORMATION

Mr ☐ / Mrs ☐ / Miss ☑ / Ms ☐ / Master ☐ / Dr ☐ / Prof ☐ / other _____

First Name Ben _____ Surname _____ DOB _____

Address 8 _____

Phone (M) _____ (H) _____ (W) _____

Email _____

Preferred contact method: (please tick) ☐ home ☐ mobile ☐ work

Emergency Contact: Name _____ Tel. _____ Relationship _____

Your Occupation _____ Employer / School _____

Who can we thank for recommending Seddon Dental? _____

If it is no one, where did you hear about us? (please kindly select one or more)

Our website ☐ / internet search ☐ / walked past ☐ / Yellowpages ☐ / local paper ☐

Do you have private dental insurance? Y ☐ / N ☐ If yes, which health fund? _____

MediBank or HCF/Manchester Unity members receive free checkups, xrays, scale and clean 2 times a year.

What is the reason for your visit today? Checkup ☐ / pain ☐ / broken tooth ☐ / Other _____

YOUR DENTAL HISTORY

Name of previous dentist _____ Location/Suburb _____

Date of your last dental visit _____ Date of your last scale clean _____

Have you ever been under the care of a dental hygienist? Y ☐ / N ☐

Date of your last in-mouth dental xray (not incl full face OPG) _____

What do you fear most about visiting the dentist? _____

How often do you brush a day? (select one): once ☐ / twice ☐ / more than twice ☐ / less than once ☐

How often do you floss? (select one): daily ☐ / 1-2 times a week ☐ / only if food is caught ☐ / never ☐

Do you notice bleeding during brushing? Y ☐ / N ☐

Do you smoke? Y ☐ / N ☐

Do you clench or grind your teeth? Y ☐ / N ☐

Do you have a "clicking" jaw Y ☐ / N ☐

Have you ever woken up with sore jaw or headache? Y ☐ / N ☐

Do you have sensitive teeth? Y ☐ / N ☐

If yes, to what? (circle one or more) cold ☐ / hot ☐ / sweets ☐ / hard foods ☐ / others _____

COSMETIC EVALUATION (This is optional. Complete only if you are interested)

Have you ever done teeth whitening before? Y ☐ / N ☐

Would you like the dentist to tell you more about teeth whitening? Y ☐ / N ☐

Do you want to know how Invisalign® can fix your crowding/ spacing? Y ☐ / N ☐

Are you happy with the appearance of your front teeth? Y ☐ / N ☐

If no, what of the following(s) do you want to improve:

Colour ☐ / crowding ☐ / gaps ☐ / chipped front teeth ☐ / stained old fillings ☐ / gummy smile ☐

YOUR MEDICAL HISTORY (It is very important to be as detailed as you can)

Have you ever had any of the following? (please select)

High / low blood pressure Y ☐ / N ☐

Excessive bleeding from surgery/cuts Y ☐ / N ☐

Mild / severe asthma Y ☐ / N ☐

Bone problems (eg. osteoporosis) Y ☐ / N ☐

Heart problems (specify) _____ Y ☐ / N ☐

Epilepsy Y ☐ / N ☐

Heart Pacemaker Y ☐ / N ☐

Hepatitis A, B or C ? (specify) _____ Y ☐ / N ☐

Artificial Heart valve Y ☐ / N ☐

HIV or AIDS last tested (when) _____ Y ☐ / N ☐

Artificial hip / joint Y ☐ / N ☐

Stomach ulcers or bowel problems Y ☐ / N ☐

Stroke (specify when) _____ Y ☐ / N ☐

Tuberculosis or other lung problems Y ☐ / N ☐

Rheumatic fever Y ☐ / N ☐

Thyroid illness Y ☐ / N ☐

Diabetes Y ☐ / N ☐

Kidney problems Y ☐ / N ☐

Do you have any allergies (eg. Penicillin, latex)? Y ☐ / N ☐

If yes, please specify _____

Are you presently under the care of a medical doctor/ specialist? Y ☐ / N ☐

If yes, for what reason? _____

Contact details of your medical doctor or specialist

Name _____ Tel. _____

Clinic location or address _____

Are you currently taking any medicines, tablets or supplements? Y ☐ / N ☐

If yes, please list below (including Aspirin, blood thinners, Arfarin, bone strengthener Fosamax)

_____ what's it for? _____

_____ what's it for? _____

_____ what's it for? _____

_____ what's it for? _____

For women, are you pregnant? Y ☐ / N ☐

Please tell us any other medical or dental conditions we haven't covered _____

_____

PATIENT SIGNATURE

Declaration: I have completed this questionnaire truthfully and to the best of my knowledge. I understand that failure to make a full disclosure may place ME under medical risk. I understand treatment notes, xrays, photos or models relating to my treatment may need to be sent to other dental practitioners and used for educational purposes. I give Seddon Dental permission to use the above contact details to contact me and send me appointment reminders.I understand payment is required at the time of treatment by cash, eftpos, cheques, VISA/Mastercards/ American Express.

Patient Signature _____ Date _____

Thank you for your patience