New Patient
Medical and Dental History

The Dentists
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Patient details:

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Miss ☐ Master Other:

Surname: Given name: DOB:

Residential Address:

Suburb: State: Postcode: Home Ph:

Wk Ph: Mobile: Email:

☐ We will send you email communications from time to time, including appointment reminders and our regular newsletter. Please tick this box if you don't wish to receive email communications from us.

Occupation: Private health insurer:

GP Name: Phone:

Medical History: (Please tick if you have had any of the following)

- ☐ Abnormal/excessive bleeding
- ☐ Angina
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Blood disorder (name below)
- ☐ Blood pressure - High / Low
- ☐ Blood thinner
- ☐ Bone disease (e.g., Osteoporosis)
  - ☐ Current or past Bisphosphonate therapy
- ☐ Cancer
- ☐ Cardiac surgery/pacemaker
- ☐ Congenital Heart disease
- ☐ Diabetes TYPE1 / TYPE2
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A / B / C / D
- ☐ HIV positive
- ☐ Immune deficiency
- ☐ Kidney / liver disease
- ☐ Neurological disorder
- ☐ Oral Ulceration
- ☐ Prosthetic joints
- ☐ Psychiatric Care
- ☐ Radiation/chemotherapy
- ☐ Reflux
- ☐ Rheumatic fever
- ☐ Steroid therapy
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other condition (name below)

Are you Pregnant: ☐ Yes ☐ No If yes, how many months: Date due:

Are you taking medication (including natural supplements)? If yes, please list

Are you a smoker: ☐ Yes ☐ No If yes, how often?:

Allergies : ☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs

☐ Other (please specify):

Emergency Contact Name: Ph: Relationship:

Privacy Policy and Signature

All personal information collected by the dentists (as part of Dental Corporation/Bupa) is handled in accordance with our privacy policy. This policy also contains information about how you can request access to your information and how you can make a complaint about the handling of your information. You can view the policy online at https://bupadental.com.au/privacy-policy.html.

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and, (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient/ Guardian Name: Signature: Date: