SEMAPHORE DENTAL
caring for your smile

It is important to know about your medical history as it could affect your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy.

NEW PATIENT FORM

TITLE: (PLEASE CIRCLE) DR MR MRS MS MISS MASTER ☐ MALE ☐ FEMALE

SURNAME: _____ GIVEN NAMES: _____

PREFERRED NAME:_____ DATE OF BIRTH: _ _ / _ _ / _ _ _ _

ADDRESS: _____

POSTCODE: _____OCCUPATION: _____

PHONE (H) _ _ _ _ _ _ _ _ (W) _ _ _ _ _ _ _ _ (M) _ _ _ _ _ _ _ _ _ _

EMAIL: _____

EMERGENCY CONTACT DETAILS

SURNAME: _____ GIVEN NAMES: _____

RELATIONSHIP TO CLIENT: _____

PHONE (H) _ _ _ _ _ _ _ _ (M) _ _ _ _ _ _ _ _ _ _

How would you like to be contacted for appointment reminders? ☐ SMS ☐ Email ☐ Phone call

WHAT MADE YOU CHOOSE US?

☐ Our Website ☐ Signs ☐ Family Doctor ☐ BUPA ☐ Yellow Pages (please circle: Book/Online) ☐ Radio
☐ White Pages (please circle: Book/Online) ☐ Friend Referral (please specify who) _____

WHO IS RESPONSIBLE FOR PAYMENT?

☐ Self ☐ Parent ☐ DVA ☐ SADS ☐ CDBS ☐ Other

Are you in a Private Health Fund? ☐ Yes ☐ No If so, specify which one: _____

MEDICAL HISTORY

Do you now, or have you ever had any of the following medical conditions? (Please tick any you have or had)

☐ Heart Disease	☐ HIV/AIDS	☐ Liver Disease
☐ Heart Murmur	☐ Epilepsy	☐ Kidney Disease
☐ Artificial Heart Valve	☐ Diabetes 1 or 2 (circle)	☐ Asthma
☐ High Blood Pressure	☐ Artificial Joint	☐ Radiation/Chemotherapy
☐ Low Blood Pressure	☐ Pacemaker	☐ Depression/Anxiety (circle)
☐ Hepatitis A/B/C(circle)	☐ Bleeding Problems	☐ Thyroid Disease
☐ Osteoporosis	☐ Cancer	☐ Arthritis

Any other conditions (including mental health) please list:.....

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	Yes	No
Are you taking any medications, supplements or injections?	□	□
Please specify _____		
Have you been hospitalised in the last 12 months?	□	□
Please specify _____		
In the past have you had any reactions to local anaesthesia?	□	□
Do you require antibiotic cover before dental treatment?	□	□
Are you or could you be pregnant? (females only)	□	□
Have you had botox?	□	□
Are you allergic to latex?	□	□
Are you allergic to Chlorhexidine?	□	□

Do you have any known allergies to medications? .....

Have you had any of the following?	**Yes**	**No**
Does your jaw click or hurt?	□	□
Do you feel you grind/clench your teeth?	□	□
Do you wear a night guard?	□	□
Do you play a contact sport?	□	□
Do you wear a mouth guard?	□	□
Have you ever had orthodontic treatment?	□	□
Have you ever had gum disease?	□	□
Do you think you have bad breath?	□	□
Do you use an electric toothbrush?	□	□
Do you experience sensitivity to hot/cold?	□	□
Does food get caught in your teeth?	□	□
Do your teeth ever hurt when you bite hard?	□	□
Do you bite your cheeks or lips often?	□	□
Do your gums ever bleed when you brush your teeth?	□	□
Would you like your teeth to be whiter?	□	□
Do you regularly floss?	□	□
Do you have any missing teeth?	□	□
Do you smoke?	□	□

What is the reason for your visit today? .....

When was your last visit to the dentist? .....

Do you experience anxiety when visiting the dentist? .....

Payment of Account: Full payment of the account is due at your appointment. If you are unable to pay your account in full, please speak to our front desk staff prior to your appointment. Should the health fund claim be rejected for any reason, the patient will be responsible for payment of the full account on the day of treatment.

Please ensure that you bring your health fund card to every appointment to claim using our HICAPS machine. If you do not have your card you will need to pay in full and claim your benefit back from your health fund directly.

Please note, you will be liable for any debt collection fees incurred if payment is not received within our settlement terms.

Appointment Cancellation and Failing to Attend Policy: We reserve your appointment at the time of booking. We provide a courtesy confirmation reminder service via SMS, telephone or email prior to all appointments. If you need to reschedule your appointment please call our clinic to arrange a suitable time.

Patients that cancel appointments less than 48 hours' notice, or fail to attend an appointment, greatly impact our ability to provide quality dental care and offer appointments to other patients in need. We understand that 48 hours' notice isn't always possible and we will take each circumstance into consideration. We reserve the right to charge a $100 cancellation fee for late notice cancellations or for missed appointments. By signing this form you have read and accept the policies listed above.

Patient's Signature: _____ Date: _____

Parent/Responsible Party's Signature: _____ Relationship to Patient: _____

(parent/guardian if under 18 years of age)