Zest Dental

New Patient Information

We are pleased to welcome you to our practice. Please complete this form. The following information is necessary to enable us to provide you with the best dental care. All information disclosed is confidential.

Surname:	**Title:**
Given Name(s):	**Date of Birth:** DD/MM/YYYY
Preferred Name:	

Address:	**Suburb:**
	Postcode:

Home Phone:	**Mobile:**
Work Phone:	**Email:**

Private Health Fund:	**Position No. on card:**

Occupation:	**Employer:**

Next of Kin

Name:	**Relationship:**	**Phone:**

In case of emergency, whom should we contact? (If different from Next of Kin)

Name:	**Relationship:**	**Phone:**

How would you like your appointment confirmed?

❏ Phone Call ❏ SMS ❏ Email ❏ None

Email Updates:
Check 'Yes' to be kept informed with updates on what is new in the practice, services and new dental techniques that may affect my next visit.

❏ Yes ❏ No

How did you hear about us?

- ❑ Referred by another patient: (name) _____
- ❑ Referred by staff: (name) _____

❑ Yellow pages	❑ Yellow Pages (Online)	❑ Internet	❑ Practice Website
❑ Passing By	❑ Live Locally	❑ Other	

Dental History
How long is it since your last thorough dental examination?

❑ 6 months	❑ 1 year	❑ 2 years	❑ 3 years	❑ Longer

Please tick any dental concerns you may have:

❑ Toothache	❑ Missing teeth	❑ Pain in face or jaw joints
❑ Sensitive teeth	❑ Unsatisfactory denture	❑ Sounds from joints
❑ Bleeding gums	❑ Rapidly decaying teeth	❑ Difficulty chewing
❑ Loose teeth	❑ Lost filling/cavity	❑ Discoloured teeth
❑ Bad breath	❑ Grinding/clenching teeth	❑ Bad appearance of teeth
❑ Dry mouth	❑ Worn/broken teeth	❑ History of smoking

Medical History

How do you rate your general health?

❑ Excellent	❑ Good	❑ Fair	❑ Poor

Who is your General Practitioner?	**Telephone:**

Are you allergic to anything? e.g. Penicillin, peanuts, latex, local anaesthetic etc. (please specify)

Are you taking any of the following?	❑ Warfarin	❑ Aspirin	❑ Plavix
Are you taking any other medications? (please specify)			

Have you had or are you suffering from any of these? (tick all that apply)

- ❑ Heart trouble/surgery
- ❑ Cardiac pacemaker
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Rheumatic fever
- ❑ Arthritis
- ❑ Thyroid trouble
- ❑ Epilepsy
- ❑ Sleep apnoea
- ❑ Stroke
- ❑ Stomach or digestive condition/reflux
- ❑ Osteoporosis
- ❑ Nervous disorders
- ❑ Asthma
- ❑ HIV/AIDS
- ❑ Liver or kidney disease
- ❑ Are you or could you be pregnant?
- ❑ Excessive or prolonged bleeding
- ❑ Radiation or chemotherapy
- ❑ Eating disorder
- ❑ Prosthetic implant/joint replacement
- ❑ Organ or bone marrow transplant
- ❑ Steroid therapy
- ❑ Bisphosphonate medication
- ❑ Do you smoke?
- ❑ Other (specify) _____

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatment.

Signature: **Name:** (PRINT) **Date:**