MOSMAN VILLAGE DENTISTRY

DR DAVID WING
BDS Hons (Syd), FRACDS
GradDipClinDent (Oral Implants)

DR JENNIFER CHANG
BDS University of Sydney

NEW PATIENT REGISTRATION FORM

Medical conditions can influence dental treatment via the incompatibility of certain drugs, predisposing conditions, and the lasting effects of some illnesses. Please assist us by answering these questions as completely as possible. This information will be treated with **complete professional confidentiality.**

PATIENT INFORMATION

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other _____

Surname _____ Given names _____

Preferred name (if applicable) _____ Date of birth _____

Home address _____ Postcode _____

Telephone (Home) _____ (Mobile) _____

Email _____ Occupation _____

Who recommended you to our practice? _____

Who is responsible for payment of fees? _____

What dental benefit / insurance do you have *(if any)*? _____

MEDICAL

Name of Medical Doctor? _____ Telephone/Suburb _____

1 Are you currently receiving any medical treatment? ☐ No ☐ Yes

If so, for what reason? _____

2 Have you ever had any of the following? *(if so, please tick)*

☐ **None of the following**

- ☐ Rheumatic fever
- ☐ Heart murmurs
- ☐ Heart problems/surgery *(eg. heart attack, angina, prosthetic valve)*
- ☐ High blood pressure
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Arthritis
- ☐ Asthma/bronchitis
- ☐ Sinus problems
- ☐ Epilepsy
- ☐ Thyroid problems
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Prosthetic joint replacement
- ☐ Liver/kidney problems
- ☐ Hepatitis A, B or C
- ☐ H.I.V / A.I.D.S.
- ☐ Cold Sores/Herpes
- ☐ Injury to head/neck region *(eg. whiplash)*
- ☐ Injury to face, teeth or jaws
- ☐ Frequent headaches/neck pain

☐ Other problems not listed above, details _____

Please turn over...

3 What medicine, tablets, pills or drugs are you currently taking (or have taken recently)?

Name of medication _____

For what reason? _____

4 Are you allergic to anything? (eg. antibiotics, latex?) ☐ No ☐ Yes

If yes, please list details _____

5 Have you ever been told you need antibiotic cover for dental treatment? ☐ No ☐ Yes

6 Have you ever had prolonged bleeding from cuts or tooth extraction? ☐ No ☐ Yes

7 Do you smoke? ☐ No ☐ Yes _____ per day

8 (Women) Are you pregnant? ☐ No ☐ Yes, expected date of confinement _____

DENTAL

1 Why do you seek dental care at this time? (Please tick)

- ☐ Checkup and Clean
- ☐ Improve cosmetic appearance of teeth/smile
- ☐ Teeth whitening
- ☐ Dental Implants
- ☐ Anti-snoring or obstructive sleep apnoea appliance
- ☐ Sensitive teeth (hot/cold/sweets/pressure)
- ☐ Toothache/pain
- ☐ Bleeding or tender gums
- ☐ Broken tooth or filling
- ☐ Remove metal fillings
- ☐ Bad breath/Mouth odour
- ☐ Clenching/grinding of teeth
- ☐ Unsatisfactory denture, crowns or bridgework
- ☐ Seeking a second opinion

☐ Other, please specify _____

2 How long since your last thorough dental examination? _____

3 Have you ever seen any dental specialists? ☐ No ☐ Yes

Details _____

4 Have you been shown how to clean your teeth and gums? ☐ No ☐ Yes

5 Do you use dental floss to clean your teeth and gums daily? ☐ No ☐ Yes

PRIVACY

We are committed to ensuring the privacy and confidentiality of all personal details and dental records.
For more information, please refer to our Privacy Policy online at **mosmanvillagedentistry.com.au/privacy-policy**

Signature _____ Date _____

PAYMENT IS REQUESTED AT THE END OF EACH VISIT.

First floor Mosman Arcade
880 Military Road, Mosman NSW 2088

Phone (02) 9969 8699
Email info@mosmanvillagedentistry.com.au

OPENING HOURS
Monday – Friday 8.30am – 5.30pm