CLARITYDENTAL

New Patient Form

Welcome to Clarity Dental. It is important for us to understand your general health as well as your dental history to plan your treatment well. You can be assured that we will safeguard this information in accordance with the guidelines issued by the Australian Dental Association. Please ask our friendly team if you have any questions.

Last name: _____ Given name(s): _____ Preferred name: _____

Date of birth: _____ Occupation: _____

How would you like your appointment reminder? Please note, if we are unable to get in touch with you to confirm your attendance for your appointment, we may have to offer the allocated time slot to someone else.

☐ Email ☐ SMS ☐ Phone call

Do you have private cover for dental? ☐ No ☐ Yes Fund name: _____

Home phone: _____ Home address: _____ Suburb: _____ Postcode: _____

Are you a member of/eligible for the following:

☐ Dentacare ☐ smile.com.au ☐ DVA (Veterans) ☐ Child Dental Benefits Schedule (CDBS)

Mobile: _____ Email: _____

Who can we thank for letting you know about Clarity Dental? _____

Emergency contact name/relationship: _____ Phone number: _____

Please tick if you have or have had any of the following medical conditions:

☐	Allergies	Details: _____
☐	Bleeding disorder(s)	Details: _____
☐	Cancer	Details: _____
☐	Diabetes	Details: _____
☐	Epilepsy	Details: _____
☐	Heart problems	Details: _____
☐	Hepatitis	Details: _____
☐	High blood pressure	Details: _____
☐	HIV/AIDS	Details: _____
☐	Joint replacement	Details: _____
☐	Lung disease	Details: _____
☐	Rheumatic fever	Details: _____

Do you smoke? ☐ Yes ☐ No Details: _____

Are you pregnant/breastfeeding? ☐ Yes ☐ No Details: _____

Have you taken or are you taking Fosamax or Actonel? ☐ Yes ☐ No Details: _____

Are you taking any other medications? ☐ Yes ☐ No *Please specify below:*

_____

Is there anything else about your medical history that we should know about? *Please specify below:*

_____

Medical doctor's name: _____ Phone number: _____

Have you had any adverse reactions to local or general anaesthetics?

☐ Yes ☐ No Details: _____

On a scale from 1 to 10 (with 10 being the most phobic), how afraid/phobic are you of the dentist? *Please rate:* ___

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Optional; this information is useful so we can plan your treatment comprehensively:

When was your last dental exam? _____ **When did you last get dental x-rays?** _____

What do you use to clean in between your teeth? Please tick:

☐ Nothing ☐ Tooth picks ☐ Floss ☐ Interdental brushes ☐ Other. *Please specify* _____

Please circle the problems listed below if they concern you:

Toothache	Bleeding gums	Dry mouth	Lumps/swellings	Gaps
Sensitive teeth	Loose teeth	Missing teeth	Worn/broken teeth	Thin lips
Pain in jaw/face	Bad breath	Decaying teeth	Gummy smile	Others

Do you usually have a good night's sleep and wake up feeling rested?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you grind your teeth?	☐ Yes	☐ No
Do you play contact sport?	☐ Yes	☐ No
Would you like your teeth to be whiter and brighter?	☐ Yes	☐ No

Photography

I consent to photographs being taken of me for my treatment. These will be kept in my confidential record.
Additionally;

I consent to my photographs being used for the purposes of medical teaching, and as such will be shown to other medical professionals. I understand that my personal information will not be linked to the images and that they will be edited to maintain anonymity. [ ] **Yes** [ ] **No**

I consent to my photographs being published as examples of dental treatment on the Clarity Dental website and social media sites. I understand that my personal information will not be linked to the images and that they will be edited to maintain anonymity. [ ] **Yes** [ ] **No**

I consent to my photographs being published as examples of dental treatment on the Clarity Dental website and social media sites. I understand that my personal information may be linked to the images and I allow my full profile to be included in these images. [ ] **Yes** [ ] **No**

I consent to my photographs that are non-clinical being displayed at the practice and/or published on the Clarity Dental website and social media sites. I understand that my personal information may be linked to the images and I allow my full profile to be included in these images. [ ] **Yes** [ ] **No**

I do not expect any compensation, financial or otherwise, for the use of these images. I understand that my consent can be withdrawn in writing at any time.

I have accurately filled out this questionnaire to the best of my knowledge and I acknowledge that I am financially responsible for the cost of dental services provided. I understand that payment is expected on the day unless this has been discussed with the dentist beforehand. **I also understand that a rebooking deposit of $60 applies if an appointment is cancelled with less than 48 hours' notice.**

_____ _____

(Signed) *(Date)*

Patient or parent/guardian's name: _____