New Patient Form

Welcome to TC Smiles Dentalcare. To ensure that we give you the best service possible please complete the following:

Title: First Name:		Surname:
Date of Birth:	Email Address:	
Residential Address:		
Suburb:	State:	Post Code:
Home phone:	Mobile:	Work phone:
Occupation:		Industry:

Emergency Contact:	Phone:	Relation:

Do you have a health fund: Y / N If yes, which one:

Name of GP:	Name of Surgery:

Have you had any of the following (please tick all that apply)?

Abnormal Bleeding ☐
Anaemia ☐
Angina ☐
Artificial Heart Valve ☐
Asthma ☐
Blood Disease ☐
Blood Pressure High ☐ Low ☐
Cancer ☐
Cardiac Surgery ☐ / Pace Maker ☐
Congenital Heart Defect ☐
Diabetes Type 1 ☐ Type 2 ☐
Epilepsy ☐
Heart Murmur ☐ / Attack ☐ / Surgery ☐
Hepatitis A ☐ B ☐ C ☐
HIV ☐ / AIDS ☐
Joint Replacement ☐
Jaundice ☐
Kidney Disease ☐
Liver Disease ☐
Nervous Disorder ☐
Oral Cancer ☐
Pregnant ☐ Due date _____
Psychological Disorders ☐
Radiation Therapy ☐
Respiratory Problems ☐
Rheumatic Heart Disease ☐
Sinus Problems ☐
Sleep issues ☐
Stroke ☐
Thyroid Disease ☐
Warfarin Medication ☐

How many cigarettes do you smoke per day? ____
How many units of alcohol do you consume a week? ____
Are you taking any medication?
Please List: _____

Do you have any allergies (drugs/food/material)?
Please List: _____

Is there anything else your Dentist or Hygienist should be aware of? _____

What is the main purpose of your visit today? _____

When and where was your last dental visit? _____

Have you ever had any of the following for dental treatment?
General Anaesthetic ☐ Intravenous Sedation ☐ Nitrous Oxide/Laughing Gas ☐

Are you experiencing any of the following dental problems?

Sensitivity to hot or cold ☐
Discoloured teeth ☐
Bleeding gums ☐
Food Trapping ☐
Snoring ☐
Bad Breath ☐
Grinding / Clenching Teeth ☐
Clicking / Pain in Jaw Joints ☐
Roughness of existing fillings ☐
Pain/Sensitivity when eating ☐

Are you concerned with?

Your Smile ☐
Crooked teeth ☐
Missing teeth ☐
Existing Crowns / Bridges / Dentures ☐
Ability to eat ☐
Amalgam (silver) fillings ☐
Gaps between your teeth ☐

Are you interested in?

Cosmetic Tooth Whitening ☐
Anti-wrinkle Injections ☐
Clear Braces ☐
Lip Fillers ☐
Implants ☐
Sleep Devices ☐

How did you hear about our practice?

Referred by existing patient ☐ *Whom can we thank:*_____

Google ☐ Signage ☐ Facebook ☐ Website ☐ Health Fund ☐

Other ☐ *Please specify:*_____

Consent for Treatment

I the undersigned, consent to the performance of dental and oral surgery procedures agreed to be advisable, including the use of local anaesthetics, and I will assume the responsibility for the fees associated with those procedures. I hereby consent to the use of study models, x-rays, computer images and photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
I am aware the that full payment is required on the day of treatment and assume full financial responsibility. I understand the practice requires a minimum 24 hours cancellation notice, and a cancellation fee of $50 may be incurred should this not occur
I have accurately completed this preclinical examination questionnaire to the best of my knowledge. I hereby authorise the dentist to render any treatment agreed upon.

Patient signature:_____ Date:_____