PALTOGLOU DENTAL CENTRE

New Patient Information Form

CONFIDENTIAL

Title: (Mr, Mrs, Dr etc) ..... Surname: .....

Given Names: .....

Preferred Name: ..... Date of Birth: .....

Home Address: .....

Suburb: ..... Post Code: .....

.....

Mailing Address: (if different to home address)

Address: .....

Suburb: ..... Post Code: .....

Please note we require at least two contact telephone numbers

Home Phone: ..... Work Phone: .....

Mobile: ..... Fax No: .....

Email: .....

Your preferred contact method: (Please tick applicable) **Email:** ☐ **SMS:** ☐ **Mobile:** ☐ **Home Phone:** ☐ **Work Phone:** ☐

Occupation: ..... Employer: .....

Do you have dental health insurance? ☐ **Yes** ☐ **No** Fund Name: ..... Card #: .....

Are you covered by Veteran Affairs? ☐ **Yes** ☐ **No** File Number: .....

How did you hear about us? .....

Do any other members of your family come to this practice? Name: .....

Name: ..... Name: .....

Contact In Case Of Emergency

Name: ..... Phone No: .....

Once you book an appointment, we will consider this a confirmed appointment and will attempt one courtesy reminder. We value your time so please value ours. Please note that a fee will be charged for a failure to attend or a late cancellation – less than 48 hours notice.

Signature: ..... Date: .....

Paltoglou Dental Centre 1007 Malvern Road Toorak Victoria 3142 Phone: +61 3 9824 7722 Fax: +61 3 9824 5800
Email: enquiries@paltogloudentalcentre.com.au Web: www.paltogloudentalcentre.com.au ABN: 74 733 934 672

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Medical History

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Family Doctors' Name:..... Phone: .....

Is your general health? (Please tick applicable) **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐

When was your last medical check up? ..... Are you allergic to any of the following? (Please tick applicable)

Penicillin ☐ **Erythromycin** ☐ **Tetracylcine** ☐ **Codiene** ☐ **Local Anaesthetic** ☐ **Fluoride** ☐

Metals (Gold/Stainless Steel) ☐ **Asprin** ☐ **Ibuprofen** ☐ **Acetaminaphen** ☐ **Latex/Rubber** ☐

Any other Medication? **Yes** ☐ **No** ☐ **If YES Please list** .....

.....

Do You Have Or Have You Ever Had: (Please tick applicable)	YES	NO		YES	NO
Heart problems	☐	☐	Contact lenses	☐	☐
Rheumatic/Scarlet fever	☐	☐	Head/Neck injury	☐	☐
High blood pressure	☐	☐	Epilepsy/Convulsions	☐	☐
Low blood pressure	☐	☐	Neurologic problems	☐	☐
Prolonged Bleeding	☐	☐	Viral infections	☐	☐
Artificial prosthesis	☐	☐	Cold sores	☐	☐
Anemia/Blood disorder	☐	☐	Severe headaches	☐	☐
Emphysema	☐	☐	Lumps/Swelling in the mouth	☐	☐
Tuberculosis	☐	☐	Hives/Hay fever/Skin rash	☐	☐
Stroke	☐	☐	Hepatitis Type ☐	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐
Sleep disorder	☐	☐	Venereal disease	☐	☐
Kidney disease	☐	☐	Tumor, abnormal growth	☐	☐
Jaundice	☐	☐	Radiation therapy	☐	☐
Thyroid/Parathyroid	☐	☐	Chemotherapy	☐	☐
Hormone deficiency	☐	☐	Psychiatric treatment	☐	☐
Ulcer/Stomach disorder	☐	☐	Depression	☐	☐
Diabetes	☐	☐	Alcohol/drug dependency	☐	☐
High cholesterol	☐	☐	Weight management	☐	☐
Gastric reflux	☐	☐	Smoker/Smoked previously	☐	☐
Osteoporosis/osteopenia	☐	☐	Female – on birth control	☐	☐
Arthritis	☐	☐	Female – are you pregnant?	☐	☐
Glaucoma	☐	☐	Male – prostate disorders	☐	☐

Anything else we should know about your medical history?.....

List of current medications: .....

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Dental History

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Previous Dentist:..... Last check up.....

When did you last have dental x-rays ..... Last Treatment (other than a cleaning) .....

How often do you see a dentist?.....

What are your immediate concerns? .....

Please answer YES or NO to the following questions:	YES	NO
Are you fearful of dental treatment?	☐	☐
Have you had an unfavourable dental experience?	☐	☐
Have you had complications after dental treatment?	☐	☐
Do you have difficulty with dental anaesthetic?	☐	☐
Have you had orthodontic treatment?	☐	☐
Have you had oral surgery?	☐	☐
Is there anything about your teeth you would like to change?	☐	☐
Have you whitened (bleached) your teeth?	☐	☐
Have you been disappointed with previous dental work?	☐	☐
Are you self-conscious about your teeth?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
Do you have problems chewing gum/bagels/hard food?	☐	☐
Has your dental appearance changed in the last 5 years?	☐	☐
Do you have pain/limited opening/locking or popping jaw problems?	☐	☐
Do you suffer tension headaches or sore teeth?	☐	☐
Do you grind your teeth?	☐	☐
Do you/or have you worn a bite appliance?	☐	☐
Have you had any cavities in the last three years?	☐	☐
Do you have a dry mouth?	☐	☐
Are you teeth sensitive to hot/cold/sweet foods	☐	☐
Have you had tooth ache/cracked fillings/cracked/chipped teeth?	☐	☐
Do you avoid brushing some areas of your mouth?	☐	☐
Do you notice holes or pitting in your teeth?	☐	☐
Have you ever been diagnosed with periodontal/gum disease?	☐	☐
Have you ever experienced gum recession?	☐	☐
Is there a history of periodontal disease in your family?	☐	☐
Do your gums bleed when eating/flossing or brushing?	☐	☐
Are your teeth becoming loose?	☐	☐
Do you notice an unpleasant taste of odour in your mouth?	☐	☐
Have you ever experienced a burning sensation in your mouth?	☐	☐

Paltoglou dental centre is a pro-active dental practice with a strong belief in preventative dental care – at a minimum we will recommend Six-monthly hygiene visits and encourage our patients to book their appointments in advance.

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