New Patient Form

The accuracy of this information is important. Thank you for completing this questionnaire with care.
Be assured that all the information you provide is kept strictly confidential.

Lumino The Dentists

Title _____ First names _____ Surname _____

Postal Address _____ Postcode _____

Telephone: Home _____ Work _____ Mobile _____

Email _____ Date of birth _____ Occupation/School _____

I wish to receive emails and texts that include appointment notifications, news or promotions ☐

Name and contact of Parent/Guardian (if appropriate) _____ Are they responsible for your fees? Y / N

Name and contact of next of kin _____

How did you hear about us ? (Please circle) TV Magazine Newspaper Website/Websearch Brochure Yellow Pages Book Street Sign

Word of mouth (Please name) _____ Other _____

Name of last dentist _____ Year of last visit _____

Have you had: ☐ Orthodontic Treatment ☐ Gum Treatments ☐ Your bite adjusted ☐ Prolonged bleeding after tooth extractions

☐ A bad dental experience ☐ A fear of seeing a dentist ☐ The need to take antibiotics prior to dental treatment

Please tick if you have any concerns regarding the following:

☐ Appearance of your teeth ☐ Your ability to chew ☐ Teeth cleaning technique ☐ Existing dental fillings or restorations

☐ Bad taste or bad breath ☐ Clicking or pain in jaw ☐ Bleeding gums ☐ Teeth tender to bite on

☐ Clenching or grinding ☐ Sensitivity ☐ Dry Mouth ☐ Food traps

☐ Interested in whiter teeth ☐ Interested in straighter teeth

How would you rate your teeth now? 1 2 3 4 5 6 7 8 9 10 What are your expectations for your new smile? 1 2 3 4 5 6 7 8 9 10

Name of medical practitioner _____ Location _____

Are you currently receiving medical treatment or taking any drugs or medicine including oral contraception or blood thinning medicine? If so please list _____

_____

Have you any allergies to medicines, anaesthetics, latex, penicillin or contact allergies? If yes please list _____

_____

Are you a smoker? Y / N Are you, or could you be pregnant? If yes how many months? _____

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

☐ Anaemia	☐ Depressive Illness	☐ Heart Murmur	☐ Nervous Problems	☐ Rheumatic Fever
☐ Arthritis	☐ Diabetes	☐ Hepatitis A, B, C, D	☐ Osteoporosis	☐ Severe Headaches
☐ Asthma	☐ Epilepsy/Seizure	☐ High Blood Pressure	☐ Pacemaker	☐ Stroke
☐ Cancer/Malignancy	☐ Excessive Bleeding or Bruising	☐ Low Blood Pressure	☐ Prosthetic Joint	☐ Tuberculosis
☐ Chest Problems	☐ Gastric Problems	☐ HIV/AIDS	☐ Radiotherapy	☐ Hearing/Sight Impairment
☐ Cold Sores	☐ Heart Condition (List below)	☐ Liver or Kidney Problems	☐ Reaction to Anaesthetic	

If you have ever had a heart condition, please specify _____

Are there any other aspects regarding your health that you think your dentist should know about? _____

_____

CONSENT FOR TREATMENT: I authorise the dentist/designated staff to perform all recommended treatment deemed appropriate by the dentist to make a thorough diagnosis. I agree to be responsible for payment of all services rendered. I understand that payment is due at time of service. Cost incurred in relation to collection of overdue accounts will be charged to the account holder. By signing below I understand and accept these terms and conditions.

Signed by Patient/Parent/Guardian _____ Date _____

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, EFTPOS AND MAJOR CREDIT CARDS. FINANCE OPTIONS AVAILABLE.