BLACKBURN DENTAL GROUP

New Patient History Sheet - Welcome to our Practice

Details of your health are especially important when planning any treatment.
Please take your time to answer our questions as completely as possible.
The following information is necessary to enable us to give maximum consideration to your time and feelings.

Personal Details

Surname:				Title:	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐
Given name:		Preferred name:		Date of birth	/ /
Address:				Postcode:	
Email address:				Employer:	
Tel: Home		Mobile		Business	
Postal Address *(if different to above)*					
Name of person responsible for fees:					
Address *(if different to above)*					
Private Health Fund:	YES ☐ NO ☐	Name of Fund:			
Do you hold a War Veteran's entitlement card?	YES ☐ NO ☐	Entitlement Number:			
Emergency Contact:		Relationship:			
Address:		P/Code:		Phone:	
Medical Doctor's name and address:					
Have any other family members been treated here?	YES ☐ NO ☐	How long since your last dental visit?			

Medical History *Please indicate if you have ever had any of the following*

	Yes	No		Yes	No
High blood pressure	☐	☐	Diabetes	☐	☐
Heart problems, defects or a pacemaker	☐	☐	Thyroid problems	☐	☐
Rheumatic fever	☐	☐	Excessive bleeding or blood disorder	☐	☐
Asthma, chest or breathing problems	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Hepatitis (Hep B, Hep C etc.)	☐	☐
Stomach or bowel problems (e.g. ulcer)	☐	☐	AIDS/HIV	☐	☐
Kidney disease	☐	☐	Cancer	☐	☐
Anxiety or depression	☐	☐	Creutzfeldt-Jakob disease	☐	☐

Do you have an artificial valve, hip or other prosthetic implant?	Yes ☐	No ☐			
Have you ever been treated for Osteoporosis?	Yes ☐	No ☐			
Are you currently receiving any medical treatment?	Yes ☐	No ☐	If so, what for?		
Please list any medications you are currently taking:					
Are you allergic to any medicines or drugs, e.g. penicillin? Please list:					
Are you allergic to latex products or rubber gloves?	Yes ☐	No ☐	Do you smoke or use tobacco?	Yes ☐	No ☐
During pregnancy dental treatment may need to be modified, please advise if you are pregnant	Yes ☐	No ☐			
What is the purpose of your first visit to our Surgery?					

Please complete next page ▶

New Patient Feedback - thankyou

How would you like to be advised of your **recalls**? [Please select one] ☐ SMS Text ☐ Email ☐ Letter

Why you chose or how you found out about **Blackburn Dental Group?**

☐ Family/Friend recommendation [please specify] _____

☐ Blackburn Dental's Website ***OR*** ☐ Another Website

☐ Passing By/Walked In/Convenient Location ☐ Yellow Pages

☐ Other [please specify] _____

Your Dental History

Previous Dentist & Address: _____

Do you suffer from headaches or facial pain?	YES ☐	NO ☐
Are you aware of clenching or grinding?	YES ☐	NO ☐
Does your jaw ever click or pop?	YES ☐	NO ☐
Have you ever had any injuries to your head or neck area?	YES ☐	NO ☐
Have you ever had an adverse dental experience which you would like to discuss?	YES ☐	NO ☐

Your Health Information and Our Privacy Policy

The policy of our practice is to follow these procedures: The information collected will be used for the purpose of providing treatment to you. Personal information will be used to address accounts to you, process payments and write to you about our services and any issues affecting your treatment.

We may disclose your health information to other health care professionals, or require it from them if it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time. Fees may apply. If any information we have about you is inaccurate, you may ask us to alter our records accordingly.

Your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice. A full copy of our privacy statement is available upon request.

Patient's Consent

I have completed this document as thoroughly as possible. I understand that my failure to disclose all health related information may place myself at risk.

Signature: _____ Date: _____

I have also read and understood Blackburn Dental Group's Privacy Policy, and consent to the use of my information in this way.

Signature: _____ Date: _____

OFFICE USE ONLY

Dentist _____

Date _____

Notes _____