New Patient Information - Adult

We at Seascape Dental are committed to excellence in dentistry and appreciate you taking the time to complete this confidential form. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us and we will be happy to help.

About You

Title _____Full Name _____Male __Female__

DOB_____ Home Phone _____Mobile_____

Work Phone _____Email_____

Address_____

Suburb_____Postcode_____State_____

Occupation _____Company_____

Dental Health Fund _____#_____Ref#___

Medicare #_____Ref# ___ Expiry date_____

Please note: Reference number refers to the allocated number next to your name.

DVA #_____ (Veterans Affairs)

Emergency Contact Person_____ Phone #_____

Preferred Method Of Contact Telephone ☐ SMS ☐ Email ☐ Letter/Mail ☐

Medical History Information

Doctor's Name _____Phone # _____

Address _____

Suburb_____Postcode_____State_____

Ever been hospitalised ☐ No ☐ Yes
If yes, explain

Medications being taken ☐ No ☐ Yes
If yes, explain

Known allergies ☐ No ☐ Yes
If yes, explain

Patient smokes ☐ No ☐ Yes
If yes, explain

Had joint replacement surgery ☐ No ☐ Yes
If yes, explain

For Females

Pregnant ☐ No ☐ Yes

If yes, how Far?

Ever Suffered From:

Please tick answer	No	Yes	If YES please provide details:
Epilepsy	☐	☐	_____
Rheumatic Fever	☐	☐	_____
High Blood Pressure	☐	☐	_____
Low Blood Pressure	☐	☐	_____
Heart Condition	☐	☐	_____
Blood Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____
Prolonged Bleeding	☐	☐	_____
HIV/AIDS	☐	☐	_____
Hepatitis	☐	☐	_____

Do you need Antibiotic cover for Dental Treatment? No ☐ Yes ☐

Please tick if you have had any of the following?

Does your jaw click or hurt?	☐	Do you think you have occasional bad breath?	☐
Do you feel you grind your teeth?	☐	Have you ever had your bite adjusted?	☐
Do you wear a night guard?	☐	Have you ever had orthodontic treatment?	☐
Have you ever had gum disease?	☐	Do your gums ever bleed when you brush your teeth?	☐
Does food get jammed between your teeth?	☐	Does floss ever tear between your teeth?	☐
Do you bite your lips or cheek often?	☐	Do your teeth ever hurt when you bite hard?	☐
Do you experience sensitivity to hot/cold	☐		

Previous dental x-rays were taken: ☐ Less than a year ago ☐ Longer than a year

Reason for today's appointment? _____

How did you hear about us/who can we thank? _____

- I agree to be responsible for payment of all services rendered on my behalf and I understand that payment is due at the time of service unless other arrangements have been made.
- We have *HICAPS* for processing private health insurance claims.
- Please note, when claiming is not possible due to issues with your health fund, as per practice policy, accounts will need to be paid in full at your appointment. We accept Visa, Mastercard, *EFTPOS* and cash.

Patient Signature _____ Date _____

Dr Carla Morassi #4755121H Dr Adam Barrett #4739871L

To allow our dental practice to give the best possible care to all of our patients, we ask to give a minimum of 48hours notice for any cancellations of appointments.