AscendDental

New Patient Details Form

The following information will assist us to provide you with the highest standard of care.
This information will be handled confidentially by all dentists and staff in accordance with your treatment.

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mst ☐ Dr ☐ Other: .....

First Name: ..... Last Name: .....

Date of Birth: ..... / ..... / ..... Occupation: .....

Home Address: ..... Suburb: ..... Postcode: .....

Mobile: ..... Home No:..... Email: .....

Family Doctor: ..... Phone No: .....

Emergency Contact: ..... Mobile: .....

Medicare no: ..... Ref no:..... Expiry Date: .....

Private Health Fund Name: ..... Member no: ..... Ref no: .....

Medical History – Do you have any of the following? Please tick.

	Yes	No		Yes	No
Anaemia / Blood Disorder			Heart Condition		
Asthma			Hepatitis - A ☐ B ☐ C ☐		
Artificial Joints / Heart Valves			HIV		
Bone Disease			Mental Health Condition		
Blood Pressure High ☐ Low ☐			Pregnant Due Date:		
Cancer - Past ☐ Present ☐			Rheumatic Fever		
Cholesterol - High ☐ Low ☐			Smoke		
Diabetes - Type I ☐ Type II ☐			Thyroid Disorder		
Epilepsy or Seizures			Ulcer / Hiatus Hernia		
Additional information if YES to any of the above/current medications/other medical conditions.					

ALLERGIES

None ☐ Latex ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Sulphur ☐

List other: _____

CANCELLATION POLICY AND ACKNOWLEDGEMENT

- Your appointment time is reserved for you. If you cancel or change your appointment without adequate notice or fail to attend, this prevents us from treating other patients who may require our services. I understand and agree to pay a $50 cancellation per half hour fee if 48 hours' notice is not given and / or if I fail to attend my appointment.
- I acknowledge the information on this form is true and accurate to the best of my knowledge. I understand it is my responsibility to report any changes in medical status or condition.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand all accounts are to be paid on the day of treatment in full.

Patient's signature: _____ **Date:** _____

(If patient is under the age of 18 or requires guardianship, then guardian to sign)

How did you hear about us? Please tick ✓

Google		Passing by	
Health Insurance Provider		Referred by:	
Other:			

When was your last dental visit? _____

Dental History – Do you have any of the following concerns? Please tick.

	Yes	No		Yes	No
Appearance of Smile			Grinding / Clenching		
Bad Breath			Jaw joint pain / Clicking		
Bleeding Gums			Loose / Missing Teeth		
Discoloured Teeth			Pain while chewing		
Food Trapping			Previous Treatment		
Gaps between the teeth			Sensitivity Hot ☐ Cold ☐		

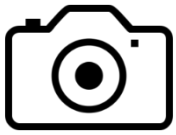

PHOTO CONSENT:

I hereby **consent / do not consent** (please circle) to my photographs being used for public media use. I understand that these images will be used in promoting treatment that I have undergone at the practice. I acknowledge that it is for educating the public and advertising purposes and I consent to the use. These images may also be shared with other medical or dental specialists for diagnosis. I thus consent to the use, publication and distribution of these photos.

I understand I won't be receiving any compensation or remuneration of these photos being used. I consent to their use with good will.

I acknowledge that I am 18 years and above, have read all the particularities of the use of my photographs and hereby consent to its use. I am aware that I am consenting to the use of my photos within the ticked boxes below.

- Face and Teeth
- Teeth only

Patient's signature: _____ Date: _____
(If patient is under the age of 18 or requires guardianship, then guardian to sign)