WELCOME TO OUR PRACTICE

Dr Trevor Sargeant
Dr Michael Cahill
Dr Sophia Malone

(02) 9905 2022 - Suite 6, Cnr Moore and Albert Streets, Freshwater NSW 2096

Patient Details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other _____

Given Names: _____

Preferred Name: _____

Date of Birth: _____/_____/_____

Email Address: _____

☐ *Tick here if you don't want to be contacted by email*

Residental Address: _____

_____

Suburb: _____

Postcode: _____

Contact: (home) _____

Contact: (mobile) _____

Contact: (work) _____

Surname: _____

Occupation: _____

Company: _____

General Practitioner: _____

Contact Number: _____

Emergency Contact Name: _____

Contact Number: _____

Relation: _____

Reminder System:

If you would like us to remind you of your appointments, please indicate your preferred method of contact:

☐ SMS ☐ Mobile ☐ Home Phone

☐ Work Phone ☐ Email

How Did You Hear About Us?

☐ Website/Google search
☐ Yellow Pages Book
☐ Yellow Pages Online
☐ Dental Care Network
☐ Health Fund. Specify: _____
☐ GP or Other Medical Professional: Please Specify:
_____
☐ Radio
☐ Practice Signage
☐ Referred by Family, Friend or Colleague?
Whom may we thank? _____
☐ Advertising: *If so, where?* _____
☐ Newspaper
☐ Mail
☐ Facebook
☐ Other: *Please Specify:* _____

Medical History: *Please tick appropriate box below*

☐Y ☐N Abnormal Bleeding
☐Y ☐N Angina
☐Y ☐N Artifical Heart Valve
☐Y ☐N Asthma
☐Y ☐N Blood Pressure ☐High ☐Low
☐Y ☐N Bisphosphonates *ie Fosamax*
☐Y ☐N Denosumab (Prolia)
☐Y ☐N Cardiac Surgery/Pacemaker
☐Y ☐N Congenital Heart Defect
☐Y ☐N Diabetes ☐Type 1 ☐Type 2
☐Y ☐N Epilepsy
☐Y ☐N Infectious Disease: _____
☐Y ☐N Joint Replacement: _____
☐Y ☐N Do you snore or experience restless sleep?
☐Y ☐N Heart Attack
☐Y ☐N Heart Murmer *Antibiotics Req.* ☐Y ☐N
☐Y ☐N Hepatitis ☐A ☐B ☐C
☐Y ☐N HIV Positive
☐Y ☐N Nervous Disorder
☐Y ☐N Oral Cancer
☐Y ☐N Pregnant: *Due date*: _____
☐Y ☐N Rheumatic Heart Disease
☐Y ☐N Smoker: *How many per day*: _____
☐Y ☐N Stroke
☐Y ☐N Thyroid Disease
☐Y ☐N Warfarin Medication
☐Y ☐N Are you interested in Teeth Whitening?
☐Y ☐N Are you taking any medications?
If yes, please list: _____
_____

Allergies:

☐Y ☐N Penicillin ☐Y ☐N Aspirin ☐Y ☐N Iodine ☐Y ☐N Sulpha Drugs ☐Y ☐N Latex

Other (Specify all allergies):_____

Patient's Signature: _____ Date: _____

WELCOME TO OUR PRACTICE

Welcome to Freshwater Dental. We look forward to maintaining your optimal dental health.

Dental History

Last Visit to the Dentist: _____ / _____ / _____

Have you ever had any reaction or complication following dental treatment in the past? *If yes, please detail:*

_____

Is there anything else the Dentist or Hygienist should be aware of? _____

Private Health Fund / Membership Number / Patient Reference Number: _____

Are you suffering from any of the following? Please tick.

- ☐ Toothache
- ☐ Sensitive Teeth
- ☐ Bleeding Gums
- ☐ Loose Teeth
- ☐ Bad Breath
- ☐ Dry Mouth
- ☐ Missing Teeth
- ☐ Unsatisfactory Denture
- ☐ Rapidly Decaying Teeth
- ☐ Lost Filling/Cavity
- ☐ Grinding/Clenching Teeth
- ☐ Worn, Broken Teeth
- ☐ Pain in Face or Jaw Joints
- ☐ Sounds from Joint
- ☐ Difficulty Chewing
- ☐ Discoloured Teeth
- ☐ Bad Appearance of Teeth

Privacy and Consent

Please be assured that this information is maintained in accordance with State and Federal Privacy Legislation. If you would like any further information about how we use and protect your personal information, please ask one of our staff for our “Personal Information, Privacy and your Dentist” document.

☐ Yes! I would like to receive a newsletter and be among the first to receive special offers, practice announcements and free dental advice and information from my dental practice.

I acknowledge that fees incurred are due and payable on the day of treatment unless prior arrangement has been made. I understand and accept that Freshwater Dental requires a minimum of 24 hours notice for cancelling or rebooking appointments. A late cancellation fee may apply. Thank You

Patient’s Signature: _____ Date: _____