Timeless Smiles Dental
Dr. Nimesh Patel
9 Hillcrest Road, Pennant Hills 2120
9484 7737 I dentistry@timelesssmiles.com.au

Timeless Smiles Dental

Confidential New Patient Form

For us to provide you with the safest and best possible care, please complete the following forms. All information is kept strictly confidential.

Personal Details:

Title: Mr / Mrs / Miss / Master / Ms (Please Circle)

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Residential Address: _____ Post Code: _____

Home Phone: _____ Mobile: _____ Work Phone: _____

Email_____ Occupation_____

Emergency Contact: Name: _____ Relation: _____Phone_____

How did you find out about our practice?

□ Google	□ Our website
□ Health Fund: _____	□ Social Media _____
□ Patient, please provide name so we can thank them _____	
□ Other, please specify_____	

Do you have Private Dental Insurance Cover □ Yes □ No If yes, please specify dental insurance:

□ Medibank	□ CBHS	□ Westfund	□ Other_____

Dental History:

Reason for your visit today: _____ Last dental visit: _____

How do you take care of your teeth?

□ Manual toothbrush	□ Electric toothbrush
□ Floss	□ Interdental brushes e.g. Piksters
□ Sensitive toothpaste	□ Whitening toothpaste

Have you ever experienced any of the following?

□ Sensitivity to hot or cold	□ Pain with chewing or biting
□ Bleeding gums?	□ Mouth odours or bad taste
□ Clenching or grinding your teeth	□ Mouth breathing
□ Head/Neck Ache	□ Food catching in between your teeth

Would you like to discuss?

□ Teeth whitening	□ Cosmetic Dental Treatments
□ Braces/Invisalign	□ Skin Rejuvenation

Have you ever had Botox/Dermal Filler □ Yes □ No If yes, when and what area did you receive it:

_____

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Medical History:

Yes	No		Yes	No	
☐	☐	Medications (Prescription, Over the Counter, Herbal, Vitamins) please list below: _____ _____ _____	☐	☐	Recent accident, Major Surgeries or Hospitalisations including hip replacements _____ _____ _____
☐	☐	Allergies (e.g. Latex, Penicillin, including food allergies). If yes, Please list below: _____ _____ _____	☐	☐	Pregnant or Breastfeeding Due Date: _____
☐	☐	Have you ever been told to take antibiotics prior to dental treatment?	☐	☐	Cancer, post cancer treatments, radiotherapy, chemotherapy
☐	☐	Heart Valve Issue	☐	☐	Stents or Shunts
☐	☐	Hypertension (High blood pressure)	☐	☐	Pacemaker, metal implants
☐	☐	Hypotension (Low blood pressure)	☐	☐	Thyroid/Gland problems
☐	☐	Bleeding Disorder	☐	☐	Anaemia
☐	☐	Diabetes Type I or II	☐	☐	Haemophilia
☐	☐	Asthma	☐	☐	Depression
☐	☐	Epilepsy	☐	☐	Smoker ☐ Current ☐ Past
☐	☐	Rheumatic Fever	☐	☐	Drug Dependence
☐	☐	Gastric Problems	☐	☐	Acid reflux
☐	☐	Severe Headaches	☐	☐	Arthritis
☐	☐	Osteoporosis	☐	☐	Hepatitis A, B or C
☐	☐	HIV	☐	☐	Thyroid conditions
☐	☐	Autoimmune Disease	☐	☐	Other_____

Please list any other conditions this practice should be made aware of:
_____
_____

Consent for Treatment, Please read the following carefully:

1) To the best of my knowledge all of the preceding answers in my medical and dental history are true and I have disclosed all information. If there are any changes to my health, I will inform the office at the next appointment.
2) I do hereby authorise and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary as well as the administration of local anaesthetic or pre-medications which may be deemed advisable and accept any associated risks
3) I agree to adhere by the conditions of the practice Cancellation Policy
4) I agree that all accounts will be settled on the day of the appointment/treatment.
5) I agree that any photos of my teeth can be shared for educational purposes or in promotional advertisements for the practice, with my identity to remain anonymous

Signature_____ **Date**_____/_____/_____

☐ Please tick this box if you are signing on behalf of a minor, who you are a guardian/parent of

Office Use Only ☐ Form Checked _____ ☐ Data entered _____ ☐ Form Scanned _____