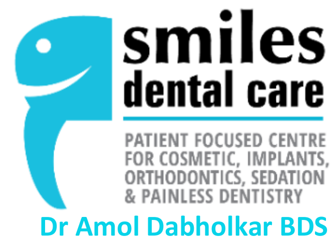
New Patient
Medical Form



Dr Amol Dabholkar BDS

Personal Information

Title Dr / Mr / Mrs / Mst / Miss / Ms / Other ____________

Surname _______________________ Given Names: _____________________________________ Date of Birth: ____/____/______

Preferred Name: _______________________________

Home Address: ____

Suburb: ____ State: _______________________________ Postcode: _________

Phone (Mobile): _______________________________________ Phone (Home): ____

Email Address: ____

Occupation: _________________________ Business Name: ________________________ Phone: ____________________________

Medicare Number: ____ Ref:_____________ Expiry:_________________

Health Fund for Dental Cover: Yes / No

Fund Name: ____

Fund Number: _______________________________ Ref:__________

Emergency Contact: __________________________ Relationship to Patient: _______________ Phone: _______________________

If the patient is a minor (under 18 years of age), is there currently a Parenting Order in place: Yes / No

Person responsible for account (must be completed if the patient is under 18)

Same as above: Yes / No If no, please complete the following details:

Full Name: ____ Relationship to Patient: ___________________________________

Address: ____

Suburb: ____ State: ________________________________ Postcode: _________

Phone (Mobile): ______________________ Phone (Home): __________________________ Phone (Work): ____________________

Email Address: ____

If a third party, insurance company / employer is responsible for the account: ____

Medical Questionnaire

General Practitioner's Name: ____________________________ Doctor's Clinic: ____

Phone: ____ Suburb: ____

Please indicate if any of the following apply to you and provide details where possible:

Allergies and Medications

- [ ] Allergies ____
- [ ] Taking Medication ____
- [ ] Taking Vitamin / Mineral Supplements __________________
- [ ] Receiving Medical Injections (Prolia) ____________________
- [ ] Taking Bisphosphonates ______________________________
- [ ] Skin Conditions ______________________________________
- [ ] Using Medicated Ointments / Creams ________________
- [ ] Using an Inhaler ____
- [ ] Taken Steroids in the Last 2 Years

Illness and Medical Procedures

- [ ] Serious/ Long Standing Illness __________________________
- [ ] Ever Hospitalised _____________________________________
- [ ] Pacemaker
- [ ] Currently Receiving Medical Care ____________________
- [ ] Artificial / Prosthetic Implants ______________________
- [ ] Heart Valve Replacement

Please indicate if you have EVER had any of the following:

Blood Conditions

- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Thrombosis
- ☐ Diabetes
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Anaemia
- ☐ Rheumatic Fever
- ☐ Aids / HIV
- ☐ Anti-Coagulant Therapy
- ☐ Haemophilia

Heart Conditions

- ☐ Angina
- ☐ Stent
- ☐ Murmur
- ☐ Heart Surgery

Lung Conditions

- ☐ Cystic Fibrosis
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ Pleurisy

Other Conditions

- ☐ Osteoporosis / Low bone density
- ☐ Kidney Disease
- ☐ Stomach Ulcers
- ☐ Gastric Ulcers
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Joint Disease
- ☐ Organ Transplant
- ☐ Bone Marrow Transplant
- ☐ Bone Disease
- ☐ Hiatus Hernia
- ☐ Cancer
- ☐ Acid Reflux
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Any Nervous System Disorder
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Thyroid Disease
- ☐ Fainting / Blackouts
- ☐ Joint Replacement Surgery

Please indicate if any of the following apply to you:

Smoking

- ☐ Currently Smoke
- ☐ Previously Smoked
- ☐ Trying to Quit

Diet

- ☐ Drink Alcohol
- ☐ Drink Soft Drink or Juice
- ☐ High Sugar Diet

Other

- ☐ Cannot be Reclined

For Females

- ☐ On Contraceptive Medication
- ☐ Could be Pregnant
- ☐ Are Pregnant No. of Weeks _______

Dental History

Please indicate if any of the following apply to you and provide details where possible:

- ☐ Previously Visited a Dentist If yes, when? ________________________________
- ☐ Previous Problems with Dental Treatment ________________________________
- ☐ Concerns About Your Teeth ________________________________
- ☐ Changes You'd Like to Make to Your Smile ________________________________
- ☐ Wisdom Tooth Removal ___________
- ☐ Clenching / Grinding of Your Teeth
- ☐ Nervous About Dental Treatment

What are you here for today?

- ☐ Clean
- ☐ Orthodontics
- ☐ Exam
- ☐ Other ___________________________
- ☐ Toothache

How Did You Hear About Smiles Dental Care?

Please indicate the option that applies to you:

☐ Recommended By ________________	☐ Google Search	☐ Facebook
☐ Walking Past / Signage	☐ Flyer	☐ Redcliffe Herald
☐ Google Maps / Places	☐ Post / Mail	☐ Messenger Magazine
☐ Word of Mouth	☐ Referred by ______________________	☐ Other ______________________

How did you find our phone number? ________________________________

I agree that the above has been completed to the best of my knowledge and is a true and accurate record; and I understand that failure to make a full disclosure may place me at undue medical risk. I hereby give permission for necessary information to be shared with a referring specialist; all other information shall remain confidential.

I also understand that Smiles Dental Care is owned and operated by The Dabholkar Group, Margate practice ABN 26 287 152 356 and Mango Hill practice ABN 79 754 401 758. I understand that payment on the day of treatment is required and I am fully responsible for the financial aspect of my dental treatment. I fully understand that any expenses, costs or disbursements incurred by Smiles Dental Care in recovering any outstanding monies, including debt collection fees and solicitor costs shall be paid by me. I further acknowledge that failure to provide 24 hours notice of cancellation of my reservation will incur a $50.00 fee; and may result in an additional $50.00 deposit requirement to schedule future reservations.

Please Note: This New Patient Medical Form in its entirety will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document, you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

Patient's Full Name (Printed): ____

Patient's Signature: ____

Date: ______________________________

Please Also Complete If the Patient is a minor (under 18 years of age):

Parent / Legal Guardian's Full Name (Printed): ____

Parent / Legal Guardian's Signature: ____

Date: ______________________________

Dentist's Signature: ____________________________________

Date: ______________________________

Office Use Only:

Form Checked and Entered By ____________________________ Form Scanned By: ______________________________________