Penrith Dentists
A.D. BOYDEN & ASSOCIATES

NEW PATIENT FORM

Title: Dr Mr Mrs Ms Miss Mst. Surname _____

First Names _____ Preferred Name _____

Name of parent or Guardian (for children under 18 years) _____

Address _____ Post code _____

Postal Address _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____ DOB _____

Are you covered for Dental treatment? Yes No Which Fund? _____

Occupation _____ Who recommended you to this practice? _____

How would you like to be contacted for maintenance treatment reminders? Letter Email SMS

Medical History _____

Who is your Doctor? _____ Phone _____

Do you see a specialist, who are they? _____ Phone _____

Have you been in hospital in the past two years? Yes No Why? _____

List all medications that you are taking _____

_____

Women: If pregnant when is your baby due? _____

Have you had any of the following?

Rheumatic Fever	Valvular Heart Disease	Heart Trouble
High Blood Pressure	Low Blood Pressure	Stroke
Diabetes	Glaucoma	Anaemia
Asthma	Bleeding Disorder	Hepatitis
Nervous Disorders	Eczema	HIV
Epilepsy	Hyperthyroidism	Reflux
Osteoporosis	Arthritis	Sinus Problems
Penicillin Allerg	Food Allergies	Other Allergies e.g. Latex

Has anyone in your family had heart disease? Yes No

Do you have any artificial joints? Yes No Where? _____

Do you take any bone density medications such as Fosamax? _____

Payment is to be made on the day of treatment.

Please note: A Cancellation fee may apply if less than 24 hours notice is given OR if you fail to attend your appointment.

Signature (Parents/Guardian if under 18) _____ Date _____