Penrith Dentists
A.D. BOYDEN & ASSOCIATES

NEW PATIENT FORM

Personal Information

Title: ____________________ Surname: ____________________

First Name: ____________________ Preferred Name: ____________________

Date of birth: __ / __ / __

Address: ____

Telephone (Home): ____________________ Mobile: ____________________

Work: ____________________

Email: ____

Health Fund for Dental Treatment: ______________________________

Emergency Contact

Next of Kin: ____________________ Phone: ____________________

Relationship: ____________________

General Practitioner Contact

Name: ____________________ Phone: ____________________

Do you see a Specialist?

Name: ____________________ Phone: ____________________

Medical History:

List medications taken/taking: ______________________________

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Have you had any of the following medical conditions or treatments?

☐ Radiation to the head/neck ☐ Arthritis ☐ Reflux

☐ Rheumatic Fever ☐ Low Blood pressure ☐ Eczema

☐ Diabetes ☐ Glaucoma ☐ Stroke

☐ Asthma ☐ Bleeding Disorder ☐ Anemia

☐ Nervous Disorder ☐ Osteoporosis/Osteopenia ☐ Hepatitis

☐ Epilepsy ☐ Hyperthyroidism ☐ HIV

☐ Penicillin Allergy ☐ Heart valve replacement or repair

☐ Drug Allergies or reactions? ______________________________

☐ Other allergies? e.g. Latex ______________________________

Has anyone in the 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 or Prolia injections?

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Care Plan: ______________________________

Women:

If pregnant when is your baby due? ______________________________

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____________

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