DR PATRICK J. MEANEY
& ASSOCIATES
DENTAL SURGEONS

New Patient Information

Thank you for providing this information; it will be treated as confidential and private by all staff. We observe the Commonwealth Privacy Act 1988 and the NSW Health Records and Information Privacy Act 2002. For a copy of our Privacy Policy please ask for our brochure or consult our website.

Last name:_____Mrs | Mr | Miss | Ms | Dr | Professor Other:_____

First name/other names:_____Preferred Name (if different to first name):_____

Address:_____

_____Post Code_____Date of Birth_____

Home Phone_____WorkPhone_____Mobile_____

E-mail address_____

Preferred way to contact you: Home Word Mobile Email (please indicate one or more)

Contact person_____Relationship_____

Their phone number?_____Alternate number_____

Your medical GP_____Address_____

Medical specialist(s)_____

Do you have any dental concerns or questions?

_____

_____

Fees

Our usual practice is to provide an accurate estimate of fees based on examination and consultation with you about your treatment. Any fee estimates given are valid for at least three months. You will receive an invoice when phases of treatment are complete and we request that you pay for treatment at each appointment when you receive an invoice. We accept cash, EFTPOS, Visa, Mastercard, and Amex. We operate a HICAPS terminal for on-the-spot claims from private health insurers.

Please complete the information on the other side of this form

Woodville House, 57-59 Elizabeth St, Moss Vale NSW 2577 • PO Box 950, Moss Vale NSW 2577
T: 4869 3111 F: 4869 3121 E: help@MossValeDental.com.au W: www.MossValeDental.com.au

Medical History-continued

Please **circle** if you now have or have had any of the following:

Angina **Heart Surgery** **Valve replacement** **Bypass** **Transplant** **Atrial Fibrillation** **Pacemaker**

Other cardiac/heart problems_____ **Have you been asked to take antibiotics before dental treatment?** _____

Do you take **Aspirin, Warfarin**, or **Apixaban [Eliquis], Rivaroxaban [Xarelto], Dabigatran [Pradaxa] Enoxaparin [Clexane]**?

Any autoimmune diseases?_____

Blood or Bleeding Disorder_____

Diabetes_____**Kidney Disease**_____

Sleep disordered breathing **Sleep Apnoea** **Snoring** **Gastric Reflux:** morning daytime evening

Hepatitis A B C ***Other*** **hepatitis**_____ **Asthma** **Seizures of any type?**

Do you smoke? If yes, how many per day and if you stopped–when?_____ **Do you Vape**/Use e-cigarettes?_____

Have you ever had **pain, discomfort, irritation, ulceration on your tongue or other parts of your mouth?**_____

Cancer – your diagnosis:_____When_____

Cancer treatment details:_____

Treatment for osteoporosis_____

Xerostomia (dry mouth) **Candidiasis** (oral thrush) **Sjögren's Syndrome**

Women – might you be **pregnant**?_____ Weeks_____

Allergies/Adverse drug reactions e.g. Penicillin and/or other:

Name of drug taken	Description of allergy/reaction	How long ago?

Contact Hypersensitivity (e.g. metal jewellery, latex)_____

Medications: Please provide a full list of medications, both prescription and non-prescription and complementary medicines (vitamins, herbal remedies, fish oil etc.) that you take regularly or over the last year. If you have had any over-the-counter analgesics/pain relief in the past 24hrs please identify these as well. [PLEASE ASK FOR ANOTHER PAGE IF YOU RUN OUT OF SPACE]

NAME	DOSE	DURATION	REASON FOR USE

If there are areas of your care or medical history that you prefer to discuss in private (not use this form) please mark this box ☐

Signature_____Date_____

Clinical photographs and x-rays: clinical photographs of teeth/gums and x-rays may be used for educational purposes and to communicate with specialists and other medical personnel; if used for education they will not identify you. If you DO NOT want them used, please advise us.