



Dr Emma Jay  
Special Needs Dentist

The Special Needs Dentistry Practice  
ABN 75 398 330 174

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# Welcome to The Special Needs Dentistry Practice!

*New Patient and Medical History Form*

**Surname** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Preferred Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Email** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Mobile** \_\_\_\_\_

**DOB** \_\_\_\_\_ **Height** \_\_\_\_\_ **cm** **Weight** \_\_\_\_\_ **kg**

## HEALTH INSURANCE

Health Fund \_\_\_\_\_ Membership No \_\_\_\_\_ Series No \_\_\_\_\_

Veteran Affairs Card \_\_\_\_\_

## EMERGENCY CONTACT/PERSON RESPONSIBLE (if more than one person, please let us know)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

## PERSON COMPLETING FORM (if different from above)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

## MEDICAL HISTORY QUESTIONNAIRE (please answer fully or discuss with dentist)

Reason for today's visit: \_\_\_\_\_

Are you receiving any medical treatment presently? Yes/No

Details \_\_\_\_\_

Have you had any serious or chronic illnesses? Yes/No

Details \_\_\_\_\_

Have you ever been hospitalised? Yes/No

Details \_\_\_\_\_

Do you have a disability? Yes/No

Details \_\_\_\_\_

Do you have a mental illness? Yes/No

Details \_\_\_\_\_

Do you have dental fear/phobia or related anxiety? Yes/No

Details \_\_\_\_\_

- Level 1, Suite 103, 22 Clarke Street, Crows Nest, NSW, 2065 • t +61 2 8622 3900 • f +61 2 8078 6033
- Suite 603, 35 Spring St, Bondi Junction NSW 2022 • 048 18 10 200 • f +61 2 8078 6033
- Shop 10, 5-7 Belgrave Street, Kogarah, NSW, 2217 • t +61 481 810 200 • f +61 2 9553 6799
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**Check all that apply:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Cancer treatment               | <input type="checkbox"/> Thyroid disorder                   |
| <input type="checkbox"/> Heart problem/treatment     | <input type="checkbox"/> Osteoporosis/low bone density  | <input type="checkbox"/> Dysphagia/swallowing disorder      |
| <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Transplanted organ/bone marrow | <input type="checkbox"/> Rheumatic fever                    |
| <input type="checkbox"/> Blood disorders             | <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Hearing, vision or speech problems |
| <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Gastrointestinal disorder      | <input type="checkbox"/> Thickened fluids/soft diet         |
| <input type="checkbox"/> Anti-coagulant medications  | <input type="checkbox"/> Asthma/lung conditions         | <input type="checkbox"/> Smoker                             |
| <input type="checkbox"/> Liver disease/Hepatitis/HIV | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Pregnant (Due date: __ / __ / __)  |
| <input type="checkbox"/> Other: _____                |   |   |

Please list current medications below: (including vitamin supplements, herbal remedies, and injections, e.g. for bones)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: (drugs, foods, etc.)

\_\_\_\_\_  
\_\_\_\_\_

*Please attach any additional information we should know before the appointment, e.g. communication keywords/phrases, sensory sensitivities, and behavioural/emotional tendencies.*

**GENERAL PRACTITIONER CONTACT DETAILS**

Medical practitioner \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

**PRIVACY STATEMENT**

Special Needs Dentistry Sydney respects your right to privacy and considers all the information you have provided on this form to be private information for the purposes of the Privacy Act (C'th) 1988 as amended ("Privacy Act"). Special Needs Dentistry Sydney collects your information to provide the most appropriate health care in an efficient way.

**CONSENT**

I agree that the above is a true and accurate record. I understand that Special Needs Dentistry Sydney requires payment on the day of the treatment. Any expenses, costs or disbursements incurred by Special Needs Dentistry in recouping any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments. I have read and agree with the privacy statement on the end of this document. This form is a guide and you should discuss any relevant conditions with your dentist prior to commencement to any dental treatments.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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