Dr Emma Jay
Special Needs Dentist

The Special Needs Dentistry Practice
ABN 75 398 330 174
w: www.specialneedsdentistry.com.au
e: info@specialneedsdentistry.com.au
M: 0481 810 200 T: 02 8622 3922

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 QUETIONNAIRE (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 a history of causing behavioural harm? Yes/No

Details _____

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For patients that may experience behavioural harm would a social story for the dental clinic be useful? Yes/No

If the dentist is running late, is this going to be an issue? Yes/No

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

Details _____

Check all that apply:

- ☐ Stroke
- ☐ Heart problem/treatment
- ☐ Pacemaker
- ☐ Blood disorders
- ☐ High blood pressure
- ☐ Anti-coagulant medications
- ☐ Liver disease/Hepatitis/HIV
- ☐ Cancer treatment
- ☐ Osteoporosis/low bone density
- ☐ Transplanted organ/bone marrow
- ☐ Epilepsy
- ☐ Gastrointestinal disorder
- ☐ Asthma/lung conditions
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Dysphagia/swallowing disorder
- ☐ Rheumatic fever
- ☐ Hearing, vision or speech problems
- ☐ Thickened fluids/soft diet
- ☐ Smoker
- ☐ Can you sit to stand? Y / N
- ☐ Can you weight bear? Y / N
- ☐ Wheelchair user: manual
- ☐ Wheelchair user: motorised /width_____cm
- ☐ Patient lifter required? Y / N
- ☐ Pregnant (Due date: __ /__ /__)
- ☐ 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 PRACTICTIONER 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.

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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 _____

CONSENT FOR CORRESPONDENCE VIA EMAIL AND MOBILE SMS

Please indicate your preference with regard to email and SMS correspondence below by ticking the appropriate box, and filling-in the relevant information.

☐ I consent to receiving appointment reminders and other correspondence for myself and/or my dependants at the following email address:_____

☐ I consent to receiving appointment reminders and other correspondence for myself and/or my dependants at the following nominated mobile telephone:_____

☐ I do not wish to receive appointment reminders or any other correspondence for myself or my family via email or mobile SMS.

Name: _____

Relationship to patient: _____

Signed: _____

Dated: _____ `