aquadental®
refreshingly different.

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Dr Peter Barry
BDSc (Hons) Qld, MDSc (Perio) Qld, MRACDS (Perio)
Dentistry & Periodontics
PROVIDER NUMBER: 063361BW

Dr Moira Hamilton BDSc Hons (Qld)
Dentistry
PROVIDER NUMBER: 0949775A

Dr Kevin Wong BDS (Otago)
Dentistry
PROVIDER NUMBER: 2936003H

new patient form

What is the purpose of today's visit?

○ Check-up ○ Discomfort ○ Dental concern ○ Medical concern ○ Cosmetic ○ Other

Your details

○ Prof ○ Dr ○ Mr ○ Mrs ○ Miss ○ Ms

First name: ______________________________

Surname: ______________________________

Address: ______________________________

____

Home number: (____) ______________________

Work number: (____) ______________________

Mobile number: ______________ Date of birth: ___/___/___

Email: ______________________________

Emergency contact person and mobile number:

____

GP Doctors' name and location:

____

Private health insurance fund: ______________________

Your Aqua Dental experience

How did you hear about Aqua Dental?

○ Yellow Pages ○ Yellow Pages Online ○ Website
○ Drive-by ○ Recommended by friend/family
○ Other ______________________________

If you were personally recommended, please provide us their name so we may thank them:

____

Why did you leave your last dentist?

____

How can we make your dental experience better?

____

Dental and medical history

What problems have you had with your teeth, gums, or mouth, or from previous dental treatments?

____

____

Please list any regular medications that you take at present including aspirin, complementary/natural/herbal medicines or vitamin supplements:

____

____

Do you have, or have you had any of the following medical conditions? **(tick all that apply)**

○ Cancer (any type)
○ Stroke
○ Heart valve disorder
○ Heart murmur
○ Heart surgery
○ Pacemaker
○ Tuberculosis
○ Anaemia
○ Prosthetic implants (knee, hip, joints, etc.)
○ Easy bruising or excessive bleeding
○ Diabetes (Type I or Type II)
○ Anxiety or panic attacks
○ High or low blood pressure
○ Hepatitis or liver disease
○ Kidney disease
○ Radiation therapy
○ Stomach or digestive conditions
○ Transplanted organ or marrow
○ Bronchitis, emphysema or COAD
○ Contact with HIV, Hepatitis B or Hepatitis C

Are you, or is it possible that you are pregnant?

○ Not applicable ○ Yes ○ No

Do you smoke? ○ Yes ○ No

If yes, how many cigarettes: ______________ per day

Please list any allergies or adverse reactions to any drugs or substances (including latex):

____

____

Your signature: ______________________

Date: _____/_____/_____

I understand:

- that my personal and medical information will be treated in the strictest confidence in accordance with the Privacy Act.
- that all treatment is to be paid for on the day of treatment and that no accounts are issued.
- that a fee may apply if a minimum of 24 hours notice is not given for cancellation or no-show for an appointment time.