# PATIENT INFORMATION

Captain / Dr / Mr / Mrs / Ms / Miss / Master (please circle)

First Name …………………………………………………………………………………………...

Surname ……………………………………………………………….DOB……………………….

Address …………………………………………………………………………………………………

………………………………………………………………………………..Post Code ………………..

Postal Address …………………………………………………………………………………….

Post Code ……………… E-mail …………………………………………………………………...

Telephone Nos:(Hm) …..……………….. (Wk)……..……………….(Mob)…………………………

Preferred Contact (please circle) – Home / Work / Mobile / Email

Occupation ………………………………………………………………………………...

Employer ……………………………………………………………………………………….

Person responsible for the account ………………………………………………………………..

Emergency contact Name ………………………………Phone:……………………………..…...

Referred by …………………………Non referral (How did you find us?)…………………….

Health Fund ……………………………………………Ref No……

General Practitioner ……………………………………………………………………….

Address ……………………………………………………………………………………

Phone Number ……………………………………………………………………………..

Name of specialist (if applicable)……………………………………………………………….

Address……………………………………………………………………………………..

Phone Number………………………………………………………………………………...

***We request and expect payment at the time of treatment. For your convenience we accept cash, cheques, eftpos, all major credit cards. Also note that you are responsible for any costs incurred by our practice for recovery of outstanding payments.***

***I understand that payment of the account is my responsibility, and that my Health Fund (if any) will not cover the full amount. I undertake to pay any expenses incurred or to be incurred in the collection of any overdue portion of this account.***

Signed: …………………………………………………………Dated: ………………….

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# PATIENT DENTAL HISTORY

Surname ____________________________________ First Name ______________________

Welcome to our practice. To help us evaluate your dental health would you please answer the following questions.
What is the reason for today's visit?
_____________________________________________________________________________
_____________________________________________________________________________

How long has it been since your last visit to a dentist (approx)_________________________
What was it for ________________________________________________________________

Any problems with previous treatment?
_____________________________________________________________________________

Have you ever had dental x-rays taken? If so, when? __________________________________
If wearing dentures, when were they constructed ? __________________________________

WHAT DENTAL PROBLEMS DO YOU HAVE? (please circle)

| | | | |
|---|---|---|---|
| Toothache | Y / N | Aware of grinding/clenching teeth | Y / N |
| Senstive teeth to hot or cold | Y / N | Worn or broken teeth | Y / N |
| Sensitive teeth to biting pressure | Y / N | Clicking or noises in jaw joints | Y / N |
| Sensitive teeth to sweet | Y / N | Locking of jaw joints | Y / N |
| Problems with food packing/impaction | Y / N | Pain in face or jaw joints | Y / N |
| Lost filling or cavity | Y / N | Suffer from migraine or headaches – Frequency | Y / N |
| Bleeding gums | Y / N | Stiff or sore facial muscles | Y / N |
| Loosening teeth/ loose denture | Y / N | Had trauma to face or head | Y / N |
| Missing teeth | Y / N | Eating is uncomfortable, painful or tiring | Y / N |
| Bad breath | Y / N | | |
| Bad appearance | Y / N | | |

Do you have any other dental problems?_________________________________________

How often do you use a toothbrush? _____________________________________________

Type of brush used – Hard Medium Soft Multi Soft Electric

Do you use dental floss? YES/NO
If so, frequency _______________________________________________________________

On a scale of 1 – 10, how would you rate your smile ________________________________
In your previous visit to a dentist, have you ever had:

a) Abnormal reaction to drugs or materials used by the Dentist ___________________
b) Difficult extractions? _________________________________________________
c) Dry sockets?_______________________________________________________
d) Excessive haemorrhage? _______________________________________________


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AH: 8239 8877

## PATIENT MEDICAL HISTORY

Surname ______________________________________ First Name ________________________
How would you rate your general health (circle) Excellent Good Fair Poor
Have you had any serious health problems in the last year YES/NO
Details ___________________________________________________________________________

Do you take any drugs/medication regularly YES/NO
If so, please list ___________________________________________________________________

Have you ever had an unfavourable reaction to Local or General Anaesthetic ? YES/NO

Have you ever had any of the following (please circle)

| | | | |
|---|---|---|---|
| Deep X-ray therapy | Y / N | Dry eyes | Y / N |
| Excessive Bleeding | Y / N | Rheumatic Fever | Y / N |
| Heart Disease | Y / N | Hyperthyroidism | Y / N |
| Blood Pressure | Y / N | Diabetes | Y / N |
| Anaemia or Blood disease | Y / N | HIV/AIDS | Y / N |
| TB or other lung disease | Y / N | Hepatitis A B or C | Y / N |
| Asthma | Y / N | Epilepsy | Y / N |
| Hay fever | Y / N | Jaundice | Y / N |
| Congenital heart disorders | Y / N | Organ transplant | Y / N |
| Heart murmur | Y / N | Osteoporosis | Y / N |
| Heart bypass or pacemaker | Y / N | Arthritis | Y / N |
| Stroke | Y / N | Glaucoma | Y / N |
| Fainting spells | Y / N | Neurosis/Nervous disorders | Y / N |
| Shortness of breath | Y / N | Venereal disease | Y / N |
| Cancer | Y / N | Dry mouth | Y / N |
| Steroids | Y / N | Blood Transfusion : Date ……….. | Y / N |

Have you ever taken (please circle)
Aspirin YES/NO Cortisone YES/NO Dilantin YES/NO Steroids YES/NO

BONE RELATED DRUGS - Pamidronate (Acedia) YES/NO Tiludronate YES/NO
Zoledronate (Zomata) YES/NO Etidronate YES/NO
Risedronate (Actonel) YES/NO Clonronate YES/NO
Alendronate (Fosamax) YES/NO
Any other medication _______________ ________________________________________
Are you allergic to any medication? __________________________________________________
Do you have any other allergies (e.g. latex) ____________________________________________
Have you ever taken any long term medication (please circle)
Warfarin YES/NO Blood pressure medication YES/NO
Any others ___________________________________________________________________
Are you a Smoker? YES/NO How many per Day? ……… For how many Years? ………..
Do you want to stop smoking YES/NO Have you sought help to stop YES/NO

Females – Are you pregnant? (Or could possibly be?) YES/NO
Have you had joint replacement YES/NO Have you had any infectious diseases YES/NO

The information contained within will be treated with strict confidence.
Signed: ____________________________________ Dated: ___________________________

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## YOUR HEALTH INFORMATION & OUR PRIVACY POLICY

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2. We may disclose your health information to other health care professionals, including specialists we may refer you to, or require it from them, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.
Signed: ___________________________________Witnessed by: _____________________________

Date: ____________________________________________________________________________

Patient/Parent/Guardian Name: _________________________________________________________

Dependents: ______________________________________________________________________

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