thedentalroom

Welcome to our Practice. In order to provide you with the highest level of care and consideration, please take the time to answer these questions completely.

PERSONAL INFORMATION

First Name: Mr / Mrs / Ms / Miss / Dr _____ Surname: _____

Preferred Name: _____ Date of Birth: _____

Street Address: _____ Postcode: _____

Email Address: _____

Telephone Home: _____ Mobile: _____ Business: _____

Postal Address (if different to above): _____

Name of person responsible for fees: _____

Address (if different to above): _____

Emergency Contact Name & Number: _____ Relationship: _____

Please tick if applicable ☐ I have Private Health Insurance with Dental Cover ☐ I have a Veterans Card

Did you discover our practice through ☐ Personal recommendation by _____

☐ Facebook ☐ Instagram ☐ Practice Signage ☐ Advertising ☐ Website

☐ Others _____

MEDICAL INFORMATION

Physician's Name: _____ Telephone: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you had any of the following? (please tick)

☐ Arthritis/Rheumatism
☐ Artificial joints (knee, hip etc.)
☐ Asthma
☐ Blood Pressure: High / Low
☐ Cancer, Tumour or other malignancy
☐ Chest Pain
☐ Congenital Heart Disease
☐ CJD: High / Low Risk
☐ Diabetes
☐ Disability (physical or developmental)
☐ Emphysema or other lung disease
☐ Epilepsy
☐ Excessive Bleeding or blood disorder
☐ Heart Ailment (heart attack, coronary artery disease, cardiac surgery)
☐ Heart Murmur
☐ Hepatitis or Liver disease
☐ HIV/AIDS
☐ Kidney Disease
☐ Osteoporosis or other bone disorder
☐ Radiation or Chemotherapy
☐ Rheumatic Fever
☐ Special Needs (Autism, Developmental Delay etc.)
☐ Stroke or other CVA
☐ Tuberculosis

Have you had any other previous illnesses? Yes / No (please list) _____

Have you ever been advised to take antibiotics before dental treatment? Yes / No

PLEASE TURN OVERLEAF

List medications you are currently taking: _____

_____

Allergy to Penicillin, Asprin or Other Drugs: ☐ Yes ☐ No Specify: _____

Allergy to Latex products or Rubber Gloves: ☐ Yes ☐ No

DENTAL INFORMATION

Reason for today's visit: _____

Former Dentist: _____ Approximate date of last dental visit: _____

Please tick if the following are a concern to you:

- ☐ Breath issues
- ☐ Broken fillings / Cracked teeth
- ☐ Blisters / Ulcers
- ☐ Cosmetic improvement
- ☐ Clench / Grind teeth
- ☐ Dry mouth
- ☐ Food collection between teeth
- ☐ Gums swollen, tender or bleeding
- ☐ Loose tooth
- ☐ Orthodontics (braces) / Invisalign
- ☐ Missing teeth
- ☐ Mouthguards
- ☐ Sensitivity to pressure or irritants (cold, hot or sweets)
- ☐ Sleep apnoea
- ☐ Snoring
- ☐ TMJ
- ☐ Toothache
- ☐ Tooth Replacement Options (dentures, crowns, bridges, implants)
- ☐ Wisdom teeth
- ☐ Zoom teeth whitening
- ☐ Others (indicate) _____

How often do you brush? _____

How often do you floss? _____

Have you ever had an allergic reaction or allergic symtoms to local or general anaesthetics? ☐ Yes ☐ No

Have you had trouble from previous dental care? ☐ Yes ☐ No

YOUR HEALTH INFORMATION & PRIVACY POLICY

The policy of our practice is to follow these procedures

The information collected will be used for the purpose of providing treatment to you. Personal information will be used to address accounts to you, process payments and write to you about our services and any issues affecting your treatment.

We may disclose your health information to other health care professionals, or require it from them if it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

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 anytime. Fees may apply. If any information we have about you is inaccurate, you may ask us to alter our records accordingly.

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 us handling of your health information, please do not hesitate to raise these concerns with our practice.

PATIENT'S CONSENT

I have completed this document as thoroughly as possible. I understand that my failure to disclose all health related information may place myself at risk.

Signature: _____ Date: _____

I have also read and understood The Dental Room Policy, and consent to the use of my information in this way

Signature: _____ Date: _____

Thank you for you assistance and welcome to The Dental Room.