Patient Information Form

It is important for us to know how you heard about our practice – please tick

Out Front shop signage (A-frame)		T.V		Website		Facebook	
Another Dental Clinic/GP Clinic		Phonebook		Radio		Google	

Or can we thank someone personally for referring you to our practice: _____

TITLE: (Please circle) Ms, Miss, Mrs, Mr, Master

FIRST NAME: _____ **LAST NAME:** _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **SUBURB:** _____ **POSTCODE:** _____

PHONE NUMBERS.'s (H): _____ **(Mob:)**_____ **(Work:)** _____

Email address: _____ **OCCUPATION:** _____

Private Health Fund: _____ **Member Card Number:** _____ **Patient I.D Number:** _____

Medicare Card Number: _____ **Patient I.D Number:** _____

Name of your Medical Centre: _____ **Name of your Medical Practitioner:**_____

Emergency contact person: _____ **Relationship:** _____ **Contact Number:** _____

Do you normally require antibiotic cover before dental treatment? **Yes / No**

Do you have any other known *allergies* to food/dust/medication? **If yes:** _____

Do you smoke? **Yes / No** **If yes, Amount per day:** _____

Are you pregnant? **Yes / No** **If so, How many weeks?:** _____

Are you currently being treated by a Doctor? **Yes / No**

Have you experienced any of the following? Please Tick ✓

Headaches		Liver or Kidney Problems/disease		Overactive Thyroid		Heart Trouble	
High Blood Pressure		Anxiety/Depression		Underactive Thyroid		Hepatitis/Aids/HIV	
Epilepsy		Allergies to Latex		Cholesterol Gastric Problems		Artificial Joints	
Low Blood Pressure		Cancer/Radiation Treatment		Bronchitis or Chest Problems		Asthma	
Diabetes		Circulatory Problems		Cold Sore		Rheumatic Fever	
Teeth Grinding		Osteoporosis or bone disease		Stroke/ Heart Attack		Jaw Pain	
Excessive Bleeding		Anaemia or other Blood Disorders		Reactions to local/general anaesthesia		Sinus Trouble	

Do you have any other current medical condition? If yes, please List: _____

Are you taking any prescription or other medications at present?

If yes, please list: _____

Have you been hospitalised for a serious illness in the past 12months? **Yes / No**

Do you have any missing teeth? **Yes / No** **Do you experience bleeding gums?** **Yes / No**

Can you tell us your brushing and flossing habits:

I usually brush: **1 x a day** ☐ **2 x a day** ☐ **more than 2 times a day** ☐
I usually floss: **1 x a day** ☐ **2 x a day** ☐ **more than 2 times a day** ☐

How often do you generally visit a dentist? **6 monthly** ☐ **Annually** ☐ **Only when you have a concern** ☐

I agree that the above is a true and accurate record as it is important to know details about your medical history as this could affect the success and safety of your dental treatment. All information provided is totally confidential and will be handled in accordance with our Privacy Policy.

I understand that Ooralea Dental Care requires payment on the day of treatment unless organised prior to the appointment with the dentist's approval. Any expenses or costs that are not received on the day or agreed date will be forwarded to a debt collection agency. We also advise further acknowledge that failure to attend any appointment without notice may also result in a non-refundable deposit requirement prior to future appointments being scheduled.
Lastly, I understand that photographs may be taken & used as part of my dental record & to assist my dentist during treatment.

Signature: _____ **Date:** _____