

Patient Information Form



Welcome to our practice! In order to assist us in providing you with the highest standard of dental care, please answer the questions below as accurately as possible. All information collected is confidential and conforms with the Federal Privacy Law Legislation.

PERSONAL DETAILS

Name: Mr/Mrs/Ms/Miss/Dr _____
(first name) (surname)

Preferred Name: _____ Date of Birth: ____/____/____

Address: _____

Suburb: _____ Post Code: _____ State: _____

Telephone: Hm: _____ Mob: _____ Wk: _____

Email: _____

Occupation: _____ Employer: _____

Preferred method of contact: Home Work Mobile SMS Any

EMERGENCY CONTACT Name: _____

Contact #: _____ Relationship to patient: _____

How did you hear about us? Please tick

- Word of Mouth Internet/Google Family/Friends Mail Passing By

PRIVATE HEALTH FUND

Private Dental Cover Fund Name: _____ Member #: _____ Ref #: _____

Medicare Child Benefit Schedule Medicare #: _____ Ref #: _____

Veteran Affairs Veteran Affairs #: _____

MEDICAL HISTORY

Are you currently receiving medical treatment: YES NO

Allergies? Please list _____

Please list **ALL** medications including supplements you are currently taking: _____

Name of Doctor: _____ Contact #: _____

Are you a smoker? NO YES approx. how many per day? _____

Please the appropriate boxes

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart murmur/rheumatic fever | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Hepatitis A,B or C |
| <input type="checkbox"/> Artificial heart/stent/pacemaker | <input type="checkbox"/> Gastric problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hip/Knee replacement |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Major Surgery (last 2 years) |

Other: _____

Are you currently taking medication to treat osteoporosis? YES

Ladies, is there a possibility you may be pregnant? YES ____ wks/mths Breastfeeding? YES

Are there any matters of a confidential nature you wish to discuss in private? YES NO

DENTAL HISTORY

When was your last dental visit? _____

How often do you brush your teeth? Once a day Twice a day Every few days Weekly

How often do you floss? Once a day Twice a day Every few days Weekly Never

What is your main reason for being here today? (You may choose more than one)

- | | |
|---|---|
| Check up & Clean <input type="checkbox"/> | Sore tooth/teeth <input type="checkbox"/> |
| Bleeding or sore gums <input type="checkbox"/> | Sensitive tooth/teeth <input type="checkbox"/> |
| Unpleasant taste or bad breath <input type="checkbox"/> | Loose tooth/teeth <input type="checkbox"/> |
| Swelling or lumps in mouth <input type="checkbox"/> | Rough/broken fillings <input type="checkbox"/> |
| Orthodontic treatment (braces) <input type="checkbox"/> | Gaps between teeth bothering you <input type="checkbox"/> |
| Issues with jaw | Improve smile |
| • clicking <input type="checkbox"/> | • colour of teeth <input type="checkbox"/> |
| • sore (can't open wide) <input type="checkbox"/> | • shape of teeth <input type="checkbox"/> |
| • clenching <input type="checkbox"/> | • change old fillings <input type="checkbox"/> |
| • grinding <input type="checkbox"/> | • other <input type="checkbox"/> |
| | |
| Mouthguard (for contact sport) <input type="checkbox"/> | Missing Teeth <input type="checkbox"/> |

I understand that payment is required on the day of treatment. I will be liable for all costs incurred by SmilesPlus Den Care in recovering overdue accounts and debts. Should you have any concerns with paying your accounts, please discuss with our staff or dentist prior to treatment being commenced.

SIGNED: _____ Date: _____

NB: Patients under the age of 18 years old must have this form signed by Parent or Guardian