PATIENT INFORMATION – CONFIDENTIAL

Please be aware, practice policy states payment is to be made at completion of your appointment. *Please answer these questions fully and discuss with the dentist (Circle Yes or No where applicable)*

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

Surname:.....First Name: .....DOB:...../...../..... Preferred Name:.....

Ph-Home:.....Mobile: ..... Work: .....

Emergency Contact Person: ..... Relationship:.....Phone:.....

Your Address:.....

Suburb: .....State:.....Postcode:.....

Email address: ..... Occupation:.....

Private Health Fund: .....Member No:.....ID No:.....

Person responsible for account (if other than self).....Phone.....

How did you find out about us?

▫ Personal Recommendation (please circle) Family Friend Colleague

Their name: .....

▫ Internet: (please circle) Our website Facebook Yellow pages Search (ie Google)

▫ Other (please specify): .....

YOUR PRIVACY

Salamanca Dental ("SD") respects your right to privacy and considers all of the information you have provided in this form as personal information for the purposes of the Privacy Act 1988 (C'th) as amended ("Privacy Act"). SD collects your personal information in accordance with National Privacy Principles, primarily to enable it to provide safe health care to you in the most appropriate and efficient way. SD may also use this information in research, training or to promote health and related services to you or for other purposes permitted under the Privacy Act.

Where possible we collect personal information directly from you and where that is not reasonable we may collect your personal information from other sources. We may collect and/or share personal information from health service providers such as health insurers, government agencies, hospitals, doctors and health specialists, to enable you to receive good quality dental care.

By providing your personal information to us in this form or by other means, you acknowledge and agree that SD may:

- collect and use your personal information to provide health and related services to you;
- collect and use your personal information to contact you to provide you with information and offers about health related services and products offered by SD; and
- disclose your personal information on a confidential basis to health service providers who may contact you in relation to health related services.

▫ **I agree** ▫ **I disagree** (please tick) to have my dental photographic images used for advertising purposes, provided my identity is protected.

Patient Signature:..... Date:...../...../20.....

Please turn over and complete the other side of this form.

Dental History

Please rate your smile 1-10 : (10 being perfect) 1 2 3 4 5 6 7 8 9 10

Please rate how anxious you are about dental treatment

(1 being no anxiety, 10 being extremely anxious) 1 2 3 4 5 6 7 8 9 10

When/where did you last visit a dentist?.....

What was your last dental experience like?.....

What is the most important thing to you when visiting a dental office?.....

What is the purpose of your visit today?.....

Medical History and Information

Name of your G.P. .....:..... Suburb:..... Ph:.....

Have you ever been hospitalised?	Yes	No	Reason:.....		
Are you currently under the care of a doctor?	Yes	No	Reason:.....		
Are you allergic to Penicillin?	Yes	No	Details:.....		
Are you allergic to Latex?	Yes	No			
Any other known allergies?	Yes	No	Details:.....		
Have you had Joint Replacement Surgery?	Yes	No	Details:.....		
Have you been advised by your Doctor that you need antibiotic cover for dental treatment?				Yes	No
For Females - Are you pregnant?	Yes	No	On contraceptive medication?:	Yes	No

Have you ever been diagnosed/treated for the following

Are you being treated for Osteoporosis?	Yes	No	Have you had Cancer?	Yes	No
Epilepsy	Yes	No	Diabetes	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No
High/Low Blood Pressure (please circle)	Yes	No	Headaches	Yes	No
Prolonged Bleeding/Blood Disease	Yes	No	Snoring/Sleep apnoea	Yes	No
Heart Conditions	Yes	No	HIV/AIDS (please circle)	Yes	No
Cardiac Surgery/Pacemaker	Yes	No	Hepatitis A B C (please circle)	Yes	No
Depression	Yes	No	Tuberculosis	Yes	No

Please provide more information on any YES answers above: .....

.....

.....

Please list ALL medications or pills you take (including pain killers/vitamins/supplement) or any other important health information :.....

.....

.....

Other

Do you smoke?	Yes	No	Number of cigarettes per day:.....	
How long have you smoked for?	.....		Are you planning to quit?:.....	
Do you consume alcohol?	Yes	No	How many glasses per week?:.....	
Have you had botox or filler injections?	Yes	No	If *Yes*, how long ago?:.....	

I declare that the information provided is true and correct, and I am aware that full payment for treatment provided is to be made at the completion of each appointment.

Patient Name:..... Signature:..... Date: ...../...../ 20.....

Parent/Guardian Name (if patient under 18):.....