

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?

- Family(provide name)..... Friend (provide name).....
- Facebook Website Internet Search Yellow pages 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:...../...../.....

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

Dental History

How would you rate your smile 1-10 (10 being perfect)? 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 at the dentist?.....

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

What is the purpose of your visit to this dental office today?.....

Medical History and Information

Name of your Medical Doctor:..... Suburb:..... Ph:.....

Have you ever been hospitalised? Yes No Reason:.....

Are you taking any medications? Yes No

Please list ALL medications or pills you are taking (including Nurofen/Aspirin/vitamins/supplement):

.....

Are you 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:.....

Do you smoke? Yes No Number of cigarettes per day:.....

- Are you planning to quit smoking Yes No

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

Do you consume alcohol? Yes No How many glasses per week?:.....

Have you ever been diagnosed/treated for the following (please circle YES or No for each condition)

Asthma	Yes	No	Epilepsy	Yes	No
Blood Disease	Yes	No	Haemophilia or prolonged bleeding	Yes	No
High Blood Pressure	Yes	No	Heart Condition	Yes	No
Low Blood Pressure	Yes	No	Hepatitis A, B, C, or TB	Yes	No
Have you had Botox or Dermal Fillers	Yes	No	HIV/ Aids	Yes	No
Diabetes	Yes	No	Are you being treated for Osteoporosis	Yes	No
Cancer	Yes	No	Rheumatic Fever	Yes	No
Anxiety/Depression	Yes	No	Snoring/ Sleep Apnoea	Yes	No
Cardiac Surgery/Pacemaker	Yes	No	Headaches	Yes	No

Any other important health information?

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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:.....

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