Salamanca™ dental

PATIENT INFORMATION – CONFIDENTIAL

Please answer these questions fully and discuss with the dentist,in need. Circle Yes or No where applicable.

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

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

Phone H:.................................….… M: …...............................….. W: …............………...…........

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

Please rate how anxious you are about dental treatment 1 2 3 4 5 6 7 8 9 10

(1 being no anxiety, 10 being extremely anxious)

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 current pain relief – Nurofen/Aspirin along with vitamins/supplements): …………………………………………………………………………………………

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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/vape? Yes No Number of cigarettes/vapes 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

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

For Females - Are you pregnant? Yes No On contraceptive medication?: Yes No

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:………/………/………