Hampstead Dental

Suite 2 / 44 Hampstead Rd, Maidstone 3012
Phone 03 9318 5599 Fax 9318 5211
info@HampsteadDental.com.au

In order to provide you with quality, tailored dental treatment, we require information about your current health status, your past medical history, social history and your personal contact details.
This information is only used in conjunction with providing you with relevant dental care.
Information is stored in accordance with the relevant legislation including the Privacy Act 2014.

PERSONAL INFO
Mr / Mrs / Miss / Ms / Miss / Mstr / Dr / Prof / other .....

Surname:……..... First Name:…….....…….. Middle Name:……..…

Date of Birth:…… Languages spoken (other than English) .....

Address:……..……Suburb…….Pcode……..

Phone: Home:…….....….....…….. Mobile:….....…..…..…….....….....

Email:…….....

Approx date of last dental visit:…….....……

CONTACTS IN CASE OF EMERGENCY

Emergency contact person ..... Phone .....

Your Employer:.....…….…..…..... Your Work Phone number .....

for school age kids School name ..... Grade .....

HEALTH FUND Extra's cover? YES / NO
Name of fund ..... Level of cover (if known) .....

REFERRAL How did you hear about us? .....

If a friend recommended us, their name so we can thank them .....

MEDICAL HISTORY

Your medical history will be reviewed routinely in accordance with the Dental Practice Board of Victoria Guidelines. Do you have a **history** (at any time) of the following? Circle all applicable.

RHEUMATIC FEVER	DIABETES	HIGH OR LOW BLOOD PRESSURE
EXCESSIVE BLEEDING	ARTIFICIAL HIP/KNEE/ANKLE	PACE MAKER
EPILEPSY	PENICILLIN ALLERGY	OTHER HEART RELATED AILMENTS
OSTEOPOROSIS	BONE PROBLEMS	THYROID PROBLEMS
STROKE	TUBURCULOSIS	ASTHMA
KIDNEY ISSUES	HEPATITIS /LIVER DISEASES	HIV/AIDS RELATED CONDITION

Have you **ever** suffered any other serious illness? Please give details and dates (at least the year)

SEE NEXT PAGE

Any Allergies?..... Adverse reactions to Anasthetics? .....

Are you presently receiving medical attention? Details:…….....

Name and phone of your GP:….....……....…

Are you currently (or in the past 12 months) taking any medicines or tablets?

Details:…….....

Are you currently, or have you recently, undertaken any psychiatric treatment? YES / NO

Do you smoke? YES / NO How many per day ..... Drink Alcohol? YES / NO
Currently or in the past taken drugs of addiction? YES / NO
For women, are you pregnant? YES / NO Due date:…….....

LIFESTYLE *(optional questions)*

Do you snore? YES / NO Do you wake with sore jaws or pain in neck/shoulders? YES / NO

Do you suffer from Tinitis (ringing in the ears)? YES / NO Does your jaw click or crack? YES / NO

How many times a day do you brush? ..... How often do you floss? .....

What type of toothbrush do you use ? MANUAL / ELECTRIC which brand? .....

What type of tooth paste do you use NORMAL / SENSITIVE / OTHER .....

Have you seen a Hygienist before for dental visits? .....

Are you happy with your smile? ..... Have you considered teeth whitening? .....

Are you concerned about how your teeth will function in later life?.....

Do you have sensitivity to cold or hot on a regular basis? .....

If there was one thing you could change about going to the dentist, what would it be – anything at all!

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PATIENT DECLARATION

It is important that the information given above are true and correct as it may affect the dental treatment options given to me. I hereby declare the above information is true, correct and complete. I also understand payment is required at the time of treatment by cash, Eftpos, major credit cards.

Client's signature:…….. Date:…….

Dentist signature:……... Date:…….Initials .....

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Bring completed form to your appointment, or fax to us on 9318 5211, or scan/email to info@hampsteaddental.com.au