Wallan Dental

FAMILY DENTAL CARE

PATIENT INFORMATION SHEET

In order for this dental practice to provide the highest standard of care, it is requested you fill in this form carefully and thoroughly.

Surname: (Mr/Mrs/Miss/Ms/Dr) ..... First name: .....

Date of birth: ...../...../..... Address: .....

..... Postcode: .....

Home phone: ..... Work phone: ..... Mobile: .....

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

Name of person responsible for fees, if not self: .....

Address: .....

..... Postcode: .....

Medicare number: ..... Medicare reference number: ..... DVA number: .....

Who should we thank for referring you? .....

Dental insurance company: .....

Is another member of your family a patient at our office? ◯ Yes ◯ No

Have you had any of the following:

◯ Heart problems
◯ Allergies to anaesthetics
◯ Blood pressure
◯ **Allergies to penicillin**
◯ Artificial joints
◯ Allergies to medications
◯ Rheumatic fever
◯ **Allergies to latex**
◯ Circulatory problems
◯ Anemia or other blood disorders
◯ Diabetes
◯ Excessive bleeding
◯ Asthma
◯ Excessive bruising
◯ Hepatitis A B C D E
◯ Ulcers (Stomach)
◯ Epilepsy
◯ Sinus trouble
◯ Liver or kidney problems
◯ Tumor history
◯ **Radiotherapy or Chemotherapy**

◯ **Other allergies to medication?** .....

Are you pregnant? ◯ Yes ◯ No If yes, what is your due date? ...../...../.....

Are you currently taking any medications? ◯ Yes ◯ No - If yes please list:

Medications	Related condition
.....	.....
.....	.....
.....	.....
.....	.....
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.....	.....

Name of your physician: .....

Address: ..... Phone: .....

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Purpose of visit: .....

Have you ever had any of the following?

- ◯ Does your jaw click or hurt?
- ◯ Do you smoke?
- ◯ Do you feel you grind your teeth?
- ◯ Do you think you have occasional bad breath?
- ◯ Have you ever had orthodontic treatment?
- ◯ Do your gums ever bleed when you brush your teeth?
- ◯ Do you wear a night guard?
- ◯ Do you experience sensitivity with hot or cold?
- ◯ Have you ever had gum disease?
- ◯ Does floss ever tear between your teeth?
- ◯ Does food get jammed between our teeth?
- ◯ Have you had teeth removed in the past?
- ◯ Do your teeth ever hurt when you bite hard?

Other notes: .....

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Previous dental x-rays were taken: ◯ Less than a year ago ◯ Longer than a year ago

How long since your last dental appointment? ..... Have you seen a Dental Hygienist before? .....

A Dental Hygienist is someone who cleans teeth, examines patients for oral diseases such as gingivitis, and provides other preventative dental care. They also educate patients on ways to improve and maintain good oral health. Dental Hygienists work hand in hand with dentists to achieve the best dental care possible.

Consent for treatment

I have completed this questionnaire to the best of my knowledge, and understand that failure to make full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays), photographs or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders..

Patient signature: ..... Date: ...../...../.....

Parent / responsible party's signature: ..... Relationship to patient: .....

At Wallan Dental, we look forward to having a healthy relationship with our patients for a very long time. Please share your interests and hobbies with us.

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Thank you for completing this patient information sheet.