DARCH DENTAL CENTRE

A Warm Welcome to our Practice!

Please fill in the following patient form. It contains Information that will assist us in providing the very best dental care for you. We respect your privacy and all information will be handled with complete confidentiality.

Title:	First Name:	Surname:
Preferred Name:		D.O.B.:
Address:		
Home Phone:	Mobile:	Preferred contact: Phone / SMS / Email
Email:		
Private Health Fund: Membership number:		 Reference number:
Occupation:		
In case of emergency who should we contact? Phone number:	Name: Relationship:	
Person responsible for payments of accounts: Phone number:		 Relationship:
Would you like to be added to our 6 monthly recall list, and/or be kept informed via email with updates on what is new at the practice, services and special offers we may have from time to time? ☐ Yes	 ☐ No	 ☐ Yes, only 6 monthly recalls

Who can we thank for recommending you to us?

☐ Practice website ☐ Private Health Insurance ☐ Walk past/Drive Past
☐ Our Facebook Page ☐ Community Newspaper ☐ Health Engine
☐ Government Clinic referral ☐ Medical Centre patient ☐ Word of Mouth

If "word of mouth" please specify who (so we can thank them): ____________________

What's the purpose of your visit today? ____________________

How long has it been since your last dental examination: ____________________

Do any of the following dental concerns apply to you?

- ☐ I experience sensitivity to Hot / Cold / Chewing / Sweet (please circle)
- ☐ I sometimes have bad breath
- ☐ Food gets caught between my teeth
- ☐ Sometimes, floss tears between my teeth
- ☐ My gums bleed when I clean my teeth
- ☐ I have gum disease
- ☐ I have had braces
- ☐ I still wear / don't wear my retainers (please circle)
- ☐ I sometimes bit my lips or cheeks
- ☐ I sometimes grind/clench my teeth
- ☐ My jaw sometimes clicks
- ☐ My jaw sometimes hurts
- ☐ My jaw sometimes locks
- ☐ I have a night guard/splint
- ☐ I feel nervous about coming to the dentist
- ☐ I have had an upsetting dental experience

How many times a day do you brush your teeth? ☐ Once ☐ Twice ☐ Rarely

How many times a day do you floss your teeth? ☐ Once ☐ Twice ☐ Rarely

How do you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐ Yes ☐ No If yes, how often? ____________________

Who is your Doctor? ____________________

Medical Centre: ____________________ **Phone:** ____________________

Are you currently receiving medical care? ☐ Yes ☐ No

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WOMEN: Are you pregnant, or is there a chance you might be pregnant? ☐ Yes ☐ No

If yes, how far along are you? ______________________

Are you currently breast feeding? ☐ Yes ☐ No

Please place a tick in the space below if you have had any of the following:

- ☐ Anxiety or depression (circle)
- ☐ Any allergic disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Chemo/radiotherapy
- ☐ Diabetes
- ☐ Fits or epilepsy
- ☐ Heart disease or heart surgery
- ☐ Hepatitis A B C D E (circle)
- ☐ High blood pressure
- ☐ HIV or AIDS (circle)
- ☐ Infectious endocarditis
- ☐ Joint replacement surgery
- ☐ Kidney disease
- ☐ Muscle diseases or wasting disease
- ☐ Open heart surgery
- ☐ Osteoporosis
- ☐ Progressive neurological disease
- ☐ Rheumatic fever
- ☐ Sinusitis or hay fever (circle)
- ☐ Thyroid disease
- ☐ Stroke (CVA)
- ☐ Other (please specify): ____

Please list any MEDICATIONS you are currently taking, or have been taking recently. Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important your dentist knows precisely what medications (if any) that you are taking.

Drug Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics, e.g. penicillin), medicines, antiseptics, local anaesthetics, preservatives and/or etc. that we should know about.

Drug Name	Nature of Reaction	How long ago

If you are in any doubt about your medication, please bring a Pharmacy Medication Summary or the bottle/packet(s) to show the dentist.

Is there anything else about your health you believe we should know? ☐ Yes ☐ No

If yes, please elaborate: ____

Would you like to discuss any matter confidentially with the dentist? ☐ Yes ☐ No

Consent:

In signing this form. I acknowledge I have accurately completed this medical history questionnaire to the best of my knowledge. I understand that my details and information are considered confidential and necessary to ensure that the best possible treatment can be provided. I understand that informed consent will be provided if any treatment is required and that all the risks associated with the treatment are outlined.

I understand that treatment at Darch Dental Centre is carried out using up to date techniques, equipment and materials. All equipment is either disposable or sterilised using an autoclave which is validated daily in accordance with AUS/NZ standards. I hereby authorise my treating dentist to take diagnostic radiographs (x-rays) and clinical photographs at the first examination and specific radiographs as required before certain procedures. I understand that these may be used for educational and training purposes.

I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentist and their staff and I assume full financial responsibility for said treatment. I understand that all fees incurred per appointment must be paid on the day of the appointment, and that appointments cancelled with less than 24 hours' notice may incur a cancellation fee of $65, to cover costs.

Patient's, parent or guardian's signature: ______________________________ **Date:** ____ /____ /_________

Dentist signature: ______________________________ **Date:** ____ /____ /_________