Patient Information Form

Jordan Springs DENTAL

Welcome to our practice! In order to assist us in providing you with the highest standard of dental care, please answer the questions below as accurately as possible. All information collected is confidential and conforms with the Federal Privacy Law Legislation.

PERSONAL DETAILS

Name: Mr/Mrs/Ms/Miss/Dr _____ _____
(first name) (surname)

Preferred Name: _____ Date of Birth: _____/_____/_____

Address: _____

Suburb: _____ Post Code: _____ State: _____

Telephone: Hm: _____ Mob: _____ Wk: _____

Email: _____

Occupation: _____ Employer: _____

Preferred method of contact: ☐ Home ☐ Work ☐ Mobile ☐ SMS ☐ Any

EMERGENCY CONTACT Name: _____

Contact #: _____ Relationship to patient: _____

How did you hear about us? Please tick ☑

☐ Word of Mouth ☐ Internet/Google ☐ Family/Friends ☐ Mail ☐ Passing By

PRIVATE HEALTH FUND

☐ Private Dental Cover Fund Name: _____ Member #: _____ Ref #: ____

☐ Medicare Child Benefit Schedule Medicare #: _____ Ref #: _____

☐ Veteran Affairs Veteran Affairs #: _____

MEDICAL HISTORY

Are you currently receiving medical treatment: ☐ YES ☐ NO

Allergies? Please list _____

Please list **ALL** medications including supplements you are currently taking: _____

_____

_____

Name of Doctor: _____ Contact #: _____

Are you a smoker? NO ☐ YES ☐ approx. how many per day? _____

Please ☑ the appropriate boxes

☐ Heart disease	☐ Kidney disease	☐ HIV/AIDS
☐ Heart murmur/rheumatic fever	☐ Liver disease	☐ Hepatitis A,B or C
☐ Artificial heart/stent/pacemaker	☐ Gastric problems	☐ Osteoporosis
☐ High blood pressure	☐ Asthma	☐ Hip/Knee replacement
☐ Low blood pressure	☐ Arthritis	☐ Stroke
☐ Bleeding disorders	☐ Diabetes	☐ Thyroid disorder
☐ Epilepsy	☐ Cancer ……	☐ Major Surgery (last 2 years)

Other: _____

Are you currently taking medication to treat osteoporosis? YES ☐

Ladies, is there a possibility you may be pregnant? YES ☐ _____ wks/mths Breastfeeding? YES ☐

Are there any matters of a confidential nature you wish to discuss in private? ☐ YES ☐ NO

DENTAL HISTORY

When was your last dental visit? _____

How often do you brush your teeth? ☐ Once a day ☐ Twice a day ☐ Every few days ☐ Weekly

How often do you floss? ☐ Once a day ☐ Twice a day ☐ Every few days ☐ Weekly ☐ Never

What is your main reason for being here today? (You may choose more than one)

Check up & Clean	☐	Sore tooth/teeth	☐
Bleeding or sore gums	☐	Sensitive tooth/teeth	☐
Unpleasant taste or bad breath	☐	Loose tooth/teeth	☐
Swelling or lumps in mouth	☐	Rough/broken fillings	☐
Orthodontic treatment (braces)	☐	Gaps between teeth bothering you	☐
Issues with jaw		Improve smile	
• clicking	☐	• colour of teeth	☐
• sore (can't open wide)	☐	• shape of teeth	☐
• clenching	☐	• change old fillings	☐
• grinding	☐	• other	☐
		……	
Mouthguard (for contact sport)	☐	Missing Teeth	☐

I understand that payment is required on the day of treatment. I will be liable for all costs incurred by SmilesPlus Dental Care in recovering overdue accounts and debts.
Should you have any concerns with paying your accounts, please discuss with our staff or dentist prior to treatment being commenced.

SIGNED: _____ Date: _____

NB: Patients under the age of 18 years old must have this form signed by Parent or Guardian