St Clair
DENTAL PRACTICE

St Clair Dental Practice

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Welcome to our Practice.

We appreciate the confidence you place in us. To assist us in providing the best possible care please complete the following questionnaire. The information provided on this form is important to your dental health and will be regarded as confidential.

If you have any questions, please do not hesitate to ask us.

Name: ______________________ Surname: ______________ Date of Birth: __________

Preferred Name: ____

Parent's Names (If under 18) ______________________________________

Home Address: ______________________ Suburb ___________ State & Post Code: __________

Billing Address (if different): ______________________________ Post Code: ______________

Home Phone: ________ Work Phone: ________ Mobile: ___________ Email: ______________

Occupation: ______________________ Employer: ______________________________

Emergency Contact: ________________ Relationship: __________ Telephone: ______________

Name of Private Health Fund: ________________ Member No: ____________________________

Name of GP: ______________________ GP's Phone: ______________________________

Person responsible for account ________________ Address: ___________________________

Phone: ______________________ Relationship to patient: ________________________

How were you referred to our practice: (Please Circle)
Yellow pages Internet Newspaper Website Family/Friend Staff Other (please specify) ________________

Dental History

(Please tick)

	Yes	No		Yes	No
Does your jaw click or hurt?			Do you think you have occasional bad breath?		
Do your gums ever bleed when you brush your teeth?			Do you feel you grind your teeth?		
Have you ever had orthodontic treatment?			Do you experience sensitivity with hot/cold?		
Do you wear a night guard?			Do you bite your lips or cheeks often?		
Have you ever had gum disease?			Does floss ever tear between your teeth?		
Have you ever had your bite adjusted?			Do you smoke?		
Does food get caught between your teeth?			Do your teeth ever hurt if you bite hard?		
Do you have difficulty opening or closing your mouth?			Any pain in the joint, ear or side of face?		

What is the reason for your dental visit today? ______________________________

When was your last dental visit? __________ Last dental cleaning? ________ Last full mouth X- rays? __________

What was done at your last dental visit? ______________________________

Do you feel nervous about having dental treatment? ______________________________

Please explain ______________________________

Have you ever had an upsetting dental visit? Tell us more ______________________________

Is there anything else about your dental condition that you wish for us to know? ______________________________

Medical History

(Please Tick)

	Yes	No		Yes	No
Diabetes			Asthma		
Heart Murmur			High Blood Pressure		
Mitral Valve Prolapse			Latex sensitivity		
Rheumatic Fever			Hepatitis		
Kidney problems			HIV/Aids		
Radiation Therapy			Liver disease		
Tumours			Chemotherapy		
Bloods Transfusions			Tuberculosis		
Haemophilia			Excessive Bleeding		
Epilepsy/Seizures			Excessive Bruising		
Blood disorders			Anaemia		
Artificial joint/Valve			Psychiatrist care		
Heart Related issues			Pacemaker or Surgery		

1)Are you allergic to any medications or drugs? Yes No If yes please specify____

2)Are you taking any medication? Please enlist. ____

3)Have you been a patient in Hospital in the last 5 years? ____

4)Have you ever taken any of the following 'Bisphosphonate' medication (please circle)
Fosamax,Bonefos, Didronel, Didrocal, Aredia, Skelid, Actonel, Zometa

5)Women, are you pregnant?(please circle) Yes / No Month____________________ Nursing? Yes / No

6)Do you have any disease, condition or problem not listed. Please explain ____

7)Do you require antibiotic cover for dental treatment? ____

Consent for Treatment

I have answered all questions honestly and to the best of my knowledge. If further information is needed, you have my permission to ask the prospective health care provider or agency, who may release such information to you. I will notify the Dentist of any changes in my health or medication. I authorize the Dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the Dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I authorise the Dentist and staff to perform and administer treatment, medication, and therapy that may be indicated. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

Patient's Signature: ____ Date: ____

Payment Terms and Conditions:

I understand that payment for dental services provided in this office to me and my dependants, are due and payable at the time services are rendered, unless financial or other approved arrangements have been made. In the event the payments are not received by agreed upon dates, I understand that a billing charge may be added to my account. I agree to be responsible for payment of all services rendered to me and my dependants. I authorise that this data may be reviewed by team members of the dental practice.

I UNDERSTAND THE PRACTICE REQUIRES AT LEAST 24 HOURS NOTICE TO CANCEL MY APPOINTMENT OR A CANCELLATION FEE MAY APPLY.

I AM AWARE THAT FULL PAYMENT IS REQUIRED AT THE TIME OF THE APPOINTMENT.

WE PROVIDE A COURTESY TO ALL OUR PATIENTS THAT OFFERS A REMINDER SERVICE IF WE HAVE NOT SEEN YOU IN OVER 6 MONTHS.

Patients Signature: ____ Date: ____