Welcome to Rockingham Dental Centre

Thank you for answering these questions to the best of your knowledge.
They are designed to allow us to ensure our treatment is compatible with your state of health.

Title: ____________ Surname: ______________________ First Name: ______________________

Preferred Name: __________________________________ Date of Birth: ______ / ______ / ______

Street Address: ____

Postal Address (if different to street address): ______________________________________

Home Phone: __________________________ Mobile: __________________________

Occupation: __________________________ Employer: __________________________

Work Phone: __________________________ Email: __________________________

Dental Insurance: ◯ Yes ◯ No Fund Name: __________________________

Membership #: __________________________ Patient ID #: __________________________

Next of Kin Name: __________________________ Next of Kin Phone: __________________________

Next of Kin Address: ____

Family Dr Name: __________________________ Address: __________________________

Ph: ____________ Medicare Number: ________________ ID: ________ Expiry: ____________

How did you find out about us? ◯ Google Search ◯ Website ◯ Yellow Pages ◯ Friend ◯ Relative

◯ Other: ____

Our preferred method of dental reminders is SMS. But if you prefer a letter ◯ or email ◯ please tick

Please take your time and read through our Privacy Policy attached to this document

SECTION A - Do you have - please tick:

High blood pressure: ◯ No ◯ Yes

Heart problems: ◯ No ◯ Yes

◯ Angina ◯ Prosthetic heart valve ◯ Cardiac pacemaker ◯ Other: ______________________

Allergies: ◯ No ◯ Yes

◯ Penicillin ◯ Local anesthetic ◯ Codeine ◯ Aspirin ◯ Latex ◯ Other:

A long-standing illness: ◯ No ◯ Yes

◯ Diabetes ◯ Epilepsy ◯ Goitre ◯ Blood disorder ◯ Asthma ◯ Kidney disease

◯ Other: ____

A bone disease: ◯ No ◯ Yes

◯ Osteoporosis ◯ Paget's disease ◯ Bone cancer ◯ Multiple myeloma ◯ Other: ______________

Have you taken bisphosphonate medication for any bone diseases in the last 10 years? ◯ No ◯ Yes

◯ Alendronate (Fosamax) ◯ Risedronate (Actonel) ◯ Pamidronate (Aredia, Pamisol) ◯ Xgeva (Denosumab)

◯ Zoledronate (Zometa) ◯ Etidronate (Didrocal) ◯ Clodronate (Bonefos) ◯ Tiludronate (Skelid)

◯ Other: ____

Bleeding problems: ◯ No ◯ Yes

◯ Spontaneous bleeding ◯ Prolonged bleeding after surgery or injury ◯ Other: ______________

A family history of any illnesses: ◯ No ◯ Yes

◯ Diabetes ◯ Heart disease ◯ Other: ______________________________________

A snoring problem: ◯ No ◯ Yes

Previous cosmetic injectables: ◯ No ◯ Yes

SECTION B - Are you:

A smoker: ◯ No ◯ Yes

Possibly pregnant: ◯ No ◯ Yes

Taking any anti-coagulants: ◯ No ◯ Yes

◯ Aspirin ◯ Warfarin ◯ Clopidogrel ◯ Pradaxa ◯ Other: ____________

Receiving medical treatment of any kind: ◯ No ◯ Yes

Please specify: ____________

Have you been hospitalised in the last 12 months: ◯ No ◯ Yes

Taking any other medicines or drugs: *(including prescription, 'over the counter' & recreational drugs)* ◯ No ◯ Yes

Please list: ____________

SECTION C - Have you ever had:

Any problems with Local or General Anesthesia: ◯ No ◯ Yes

Please specify: ____________

A joint replacement: ◯ No ◯ Yes

Please specify: ____________ Date/year of surgery ____________

Rheumatic fever: ◯ No ◯ Yes

A heart attack: ◯ No ◯ Yes

A stroke: ◯ No ◯ Yes

Radiation treatment (not films): ◯ No ◯ Yes

Radium or cobalt treatment: ◯ No ◯ Yes

Hepatitis: ◯ No ◯ Yes

Jaundice: ◯ No ◯ Yes

Cortisone treatment: ◯ No ◯ Yes

A gastric ulcer: ◯ No ◯ Yes

Popping, clicking or pain in your jaw joints: ◯ No ◯ Yes

Please specify: ____________

PATIENT DECLARATION

- I agree to advise the Dentist if I have any change to my medication or medical condition.
- I agree that if I do not pay my account within normal trading terms, you may recover from me all the reasonable costs incurred in collecting that debt.
- By signing below I am confirming that all the information shown on this form is true and correct at the time of my visit.

Patient's Signature: ____________ Date: ___ / ___ / ___

PATIENT DECLARATION (future updates only)

Patient's Signature: ____________ Date: ___ / ___ / ___

Patient's Signature: ____________ Date: ___ / ___ / ___

Patient's Signature: ____________ Date: ___ / ___ / ___

Have you had any of the following?

Title: ________________ Surname: ______________________________ First Name: ____________________________

Does your jaw click or hurt? ❍ Yes

Do you feel you grind your teeth? ❍ Yes

Do you think you have occasional bad breath? ❍ Yes

Have you ever had orthodontic treatment? ❍ Yes

Do your gums ever bleed when you brush your teeth? ❍ Yes

Do you wear a night guard? ❍ Yes

Do you experience sensitivity with hot/cold? ❍ Yes

Have you ever had gum disease? ❍ Yes

Does floss ever tear between your teeth? ❍ Yes

Have you ever had your bite adjusted? ❍ Yes

Does food get jammed between your teeth? ❍ Yes

Do you bite your lips or cheek often? ❍ Yes

Do your teeth ever hurt when you bite hard? ❍ Yes

Are you unhappy with the appearance of your teeth or smile? ❍ Yes

Are you interested in any of the following: (please tick)

❍ Orthodontic treatment ❍ Teeth Whitening ❍ Muscle Relaxants ❍ Lip Fillers

Other Notes: ____

____

How long since your last dental appointment? ____________________________________

How often do you have dental examinations? ______________________________________

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

Consent for treatment

I hereby authorise 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 agree to the use of anesthetics', sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.
I understand I can ask for a complete recital of any possible complications.
I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents.
I understand that payment is due at the time of service unless other arrangements have been made.
I authorise that this data may be reviewed by team members of the dental practice.

Patient signature: ______________________________ Date: ______________________________

Parent/ Guardian signature: ____

Parent/ Guardian print name: ____

Relationship to patient: ____