Patient Details /Update

CENTRE FOR
AESTHETIC & IMPLANT
DENTISTRY

Thank you for choosing us for your dental care.

Please complete the following information for our confidential records.
If are experiencing any difficulty in completing any of our forms our staff would be pleased to assist.

PERSONAL DETAILS _____

Surname	Mr / Mrs / Miss Ms / Dr (Please Circle)	Other Names

D.O.B	Age

Home Address	Post Code

Tel (Home)	Tel (Work)	Tel (Mobile)

Fax	e-mail Address

Occupation	Business Firm / Employer

EMERGENCY CONTACT _____

Name	Relation

Tel (Home or Work)	Tel (Mobile)	Primary Language

MEDICAL PRACTITIONER or PHYSICIAN _____

Physician's Name	Tel

HEALTH INSURANCE _____

Do You Have Dental Insurance? NO ☐ YES ☐

Do You Have Hospital Cover? NO ☐ YES ☐

If Yes above, which fund? _____

WHO REFERRED YOU TO US _____

☐ Your Dentist or specialist

☐ Recommendation by a patient or other organization

☐ Yellow Pages:
- ☐ Main Display Ad? or,
- ☐ Locality Section? If so which locality?
- ☐ Local Yellow Pages Directory?

☐ Advertisement:
- ☐ Local Newspaper
- ☐ Main Newspaper – Details:
- ☐ TV or Radio – Details:

☐ Internet:
- ☐ Google or other search engine
- ☐ Yellow Pages Online
- ☐ Other – Details:
- ☐ Please indicate the main KEYWORDS that you googled ABOVE

Provide Details Below:

Medical History / Update

It is important that all the questions in this form are answered accurately to assist us in providing the best possible treatment for you and your safety.

YOUR NAME: _____ **AGE:** _____

ALLERGIES _____

Are you allergic to Penicillin? NO ☐ YES ☐

Are you allergic to latex (Rubber)? NO ☐ YES ☐

Are you allergic to any other substance, food or medicine? NO ☐ YES ☐

If Yes, please state which: _____

MEDICATION _____

Are you taking any drug, pill or medicine? NO ☐ YES ☐

Please list your medication and how you take them:

_____

_____

For Your Safety, DO NOT Omit any Information

DENTAL PROSTHETICS _____

Do you have dentures, crowns/bridges, or loose teeth? NO ☐ YES ☐

If yes, give details:

_____

MEDICAL & HEALTH HISTORY _____

Please indicate if you ever had or suspect of having any of the following CONDITIONS:

	NO	YES		NO	YES
High Blood Pressure	☐	☐	Asthma	☐	☐
Angina	☐	☐	Chronic Bronchitis	☐	☐
Heart Attack	☐	☐	Tuberculosis	☐	☐
Cardiac Surgery	☐	☐	Diabetes	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐
Endocarditis	☐	☐	HIV / AIDS	☐	☐
Excessive Bleeding	☐	☐	Hepatitis B or C	☐	☐
Stroke	☐	☐	Glaucoma	☐	☐
Epilepsy	☐	☐	Bone Disease	☐	☐
Pneumonia	☐	☐	Scarlet Fever	☐	☐
Anaemia	☐	☐	Gout	☐	☐
Heart Murmur	☐	☐	Clots or DVT	☐	☐
Anxiety	☐	☐	Depression / Mental Illness	☐	☐
Arthritis	☐	☐	Thyroid Disorder	☐	☐

If you ticked Yes to any of the above Conditions or Symptoms, please provide further details:

_____

_____

RECENT HEALTH _____

In the last 6 months have you had any of the following SYMPTOMS:

	NO	YES		NO	YES
Cough	☐	☐	Indigestion	☐	☐
Breathlessness	☐	☐	Bruising	☐	☐
Palpitations	☐	☐	Fits or Blackouts	☐	☐
Heart Murmur	☐	☐	Infection	☐	☐
Chest Pain	☐	☐	Clots	☐	☐
Cold	☐	☐	Flu / Influenza	☐	☐

Do you have an artificial heart valve or other prosthetic implant? NO ☐ YES ☐

If Yes, please provide details: _____

Ladies, Are you pregnant or breastfeeding? NO ☐ YES ☐

If pregnant, how far: _____

BONE DISEASE OR METASTATIC DISEASE _____

Do you have any **bone disease** such as osteoporosis, Paget's disease, cancer with spread to bone (ie. breast, prostate, liver, lung and kidney), multiple myeloma, other bone conditions? NO ☐ YES ☐

Are you on any **bisphosphonate medication** such as fosamax, alendronate, risedronate, disodium pamidromate, zoledronic acid, etidronate, sodium clodronate, tiludronate? NO ☐ YES ☐

Have you ever been diagnosed with cancer, or a pre-cancerous condition? NO ☐ YES ☐

If Yes, please provide details: _____

Do you have any other serious illness? NO ☐ YES ☐

If Yes, please provide details: _____

_____

_____

_____

RECREATIONAL/SOCIAL HISTORY _____

Do you smoke? NO ☐ YES ☐

If Yes, how many per day? _____

How often do you consume alcohol?

Never ☐ Occasionally/Socially Only ☐ 2-4 times per week ☐ Daily ☐

Do you take recreational drugs? NO ☐ YES ☐

If Yes, please give details? _____

PRESENTING COMPLAINT_____

What are your **reasons** for seeking dental treatment and what is concerning you <u>the most</u>?

_____

_____

_____

_____

_____

DENTAL HISTORY

How long since your last check-up? _____

Are you able to eat and chew all food satisfactorily? NO ☐ YES ☐

Are you satisfied with the appearance of your teeth? NO ☐ YES ☐

Are you experiencing any pain or discomfort with your teeth? NO ☐ YES ☐

If you are experiencing pain please indicate how severe by circling a number:

0 1 2 3 4 5 6 7 8 9 10

No Pain ⇨ ⇨ Worsening ⇨ ⇨ Excruciating Pain

Tick ANY or ALL boxes corresponding to where the pain or problem is:

☐ Upper ☐ Front teeth ☐ Back/Side teeth ☐ Right ☐ Left

☐ Lower ☐ Front teeth ☐ Back/Side teeth ☐ Right ☐ Left

Do you get any pain or discomfort with your jaws, jaw joints or face? NO ☐ YES ☐

Do you have a click or grate when you open or close your mouth? NO ☐ YES ☐

Do you have headaches, earaches, or neck pain? NO ☐ YES ☐

Do you frequently experience sinus problems? NO ☐ YES ☐

Do you grind or clench your teeth? NO ☐ YES ☐

Do you have a stiff or sore jaw in the morning? NO ☐ YES ☐

Any serious trouble associated with any previous dental treatment or anaesthetic procedures? NO ☐ YES ☐

If yes, please explain:

_____

_____

_____

RESPONSIBILITY & CONSENT STATEMENT _____

For: _____

I have completed this questionnaire to my best knowledge and understand that failure to make a full disclosure may place me (or the above named) at undue medical risk. I also give my consent to procedures, medications or anaesthetics to be administered for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for my self or the above named, regardless of insurance coverage, medicare benefits or tax refunds.

I agree and accept that I will be liable for a cancellation fee of $140 per ½ hour segment as a minimum plus costs unless sufficient notice is given (48 hours notice is required for appointments of longer than 1 hour). I also understand that any legal and debt collection fees associated with an unpaid account will be at my cost.

SIGN HERE

Signed _____

Date _____

NOTICE REGARDING ADVERTISING

Please note that there have been recent changes in the guidelines for advertising of regulated health services. We are currently making every effort to review all our intenet and media publications to ensure that they are accurate, comply with the guidelines and do not create unrealistic expectations of treatment. Please note that any before and after pictures used in any of our advertisments or publications, references as to the impact of treatment on the quality of life or timeframes given for any particular treatment are examples only and may not represent what is possible or advocated for your individual circumstances, concerns or desires. Results vary from patient to patient. A full assesment by one of our qualified dentists is required before any recommendations can be provided. Please note that there is no specialty dedicated to dental implants in Australia, and it is inappropriate for anyone to hold themselves out to be a specialist in dental implants. All our dentists are fully qualified and are registered as dental surgeons with Australian Health Practitioners Registration Authority. Please note that every surgical or dental procedure carries risks. Before proceeding, you may wish to seek a second opinion from another appropriately qualified health practitioner. We have published Terms and Conditions and a disclosure statement on our website and a copy is also available from our reception on request. If there is anything that you have noticed in our advertising that you feel is inappropriate, explicit, self promotional or in any way misleading, we would greatly appreciate if you could let us know to help us in our review process."

Your Comments:

Signature,

Date:

Privacy Policy

YOUR HEALTH INFORMATION

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

We respect your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our facility and to whom this information might be disclosed. The policy of this practice is to follow these procedures:

1 The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2 We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

3 We may also use parts of your health information and dental records for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4 Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5 If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice; or any person who is NOT a participant of a training and education program, without your prior consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Please note that your treatment plan will often be posted to your referring doctor or dentist, as required by Medicare. If you have any objection, you must let us know <u>in writing</u>.

Please sign here as confirmation that you have read and understood our privacy policy, and that you consent to the use of your health information in this way.

Signature