DENTAL CARE PROFESSIONALS

Welcome to DCP Brighton and Adelaide. All personal information collected will greatly assist us in our effort to provide you with the highest possible dental care.

All details provided will be treated with complete professional confidentiality.

PERSONAL DETAILS

SURNAME	TITLE	GIVEN NAME
PREFERRED NAME	DATE OF BIRTH / /	OCCUPATION
ADDRESS		SUBURB
POSTCODE	EMAIL ADDRESS	
HOME PHONE ( )	MOBILE	WORK
PRIVATE HEALTH FUND (if any)		CARD No
MEDICARE CARD No - -	POSITION No ON CARD	EXPIRY DATE /
GENDER *(please circle)* MALE FEMALE	NATIONALITY	

PREFERENCE FOR APPOINTMENT CONFIRMATION (please circle):	SMS	Email	Telephone	Do Not Confirm

NEXT OF KIN / EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE

MEDICAL HISTORY

Have you had or are you suffering from any of the following? (Please tick)

☐ Heart / Vascular Disorder *(specify)*_____
☐ Blood Disease / Bleeder *(specify)*_____
☐ Blood Pressure Problem
☐ Rheumatic Fever
☐ Bone Disease (Pagets)
☐ Osteoporosis
☐ Cancer *(specify)*_____
☐ HIV / AIDS
☐ Hepatitis B or C *(specify)*_____
☐ Arthritis
☐ Diabetes *(specify)*_____
☐ Liver or Kidney Disease *(specify)*_____
☐ Asthma
☐ Epilepsy
☐ Nervous Disorders
☐ Eating Disorder *(specify)*_____
☐ Sleep Apnoea
☐ Stomach or Digestive Condition / Reflux_____
☐ Joint Replacement (eg hip, knee)_____
☐ Other (specify)_____
☐ Are you, or could you be pregnant?
☐ Smoker_____

Who is your general practitioner?	Telephone

Are you allergic to anything? E.g.: Local Anaesthetic, Latex, Penicillin, Peanuts, etc *(please specify)*

_____

Please Complete Other Side of Form

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CARDIAC CONDITIONS

Please tick any that apply to you

☐ Heart Surgery within past 6 months
☐ Pacemaker
☐ Vascular Surgery (replaced artery) past 6 months
☐ History of heart murmur (mitral valve prolapsed)
☐ Previous bacterial endocarditis
☐ Systemic pulmonary shunt
☐ Congenital Heart Defect
☐ Acquired valvular dysfunction
☐ Artificial heart valve
☐ History of rheumatic fever

Please list any medications (including natural remedies) you are taking:

_____
_____
_____

DENTAL HISTORY

How long is it since your last dental check-up: ☐ 6 months ☐ 1 year ☐ 2 years ☐ Longer

Please tick any dental concerns you may have:

☐ Toothache
☐ Sensitive Teeth
☐ Bleeding Gums
☐ Loose Teeth
☐ Bad Breath
☐ Dry Mouth
☐ Missing Teeth
☐ Unsatisfactory Denture
☐ Rapidly Decaying Teeth
☐ Lost Filling / Cavity
☐ Grinding / Clenching Teeth
☐ Worn / Broken Teeth
☐ Pain in Face or Jaw Joints
☐ Sounds from Jaw Joint
☐ Difficulty Chewing
☐ Discoloured Teeth
☐ Bad Appearance of Teeth
☐ Were you a Smoker?

HOW DID YOU HEAR ABOUT US?

☐ Referred by another patient (who?)_____
☐ Referred by a staff member (who?)_____
☐ Yellow Pages
☐ Yellow Pages online
☐ Google
☐ Other_____
☐ Practice Website
☐ Passing by
☐ ADA Website

I accept the ultimate responsibility for payment of all dental treatment carried out on myself, and may include any fees generated from missed appointments or appointments cancelled with less than 24 hours notice, and agree to pay all fees at the time of the appointment unless prior arrangements have been made. In default, I agree to pay all account handling fees and collection charges for overdue accounts.

Patient Signature_____ Date_____