hampton dental centre

Welcome to our practice

NEW PATIENT INFORMATION FORM

In order to provide you with the highest standard of dental care it is important for us to understand your general health and past medical and dental history.
Some of this information may be of a personal nature. Please be assured that we will safeguard this information in accordance with the guidelines issues by the Australian Dental Association, Dental Practice Board of Australia and the Privacy Act.
Please do not hesitate to ask should you have any questions regarding the information requested below.

Title: First Name: Surname: Preferred Name: Gender:

Do you Identify as Aboriginal or Torres Strait Islander : **Yes** ☐ **No** ☐

Date of birth: **Email:**

.....

Mobile Number: Home Number: Work Number:

Address:

Your preferred contact method (tick) SMS ☐ EMAIL ☐ PHONE ☐

Mailing address (if different to above) .....

Do you have dental health insurance? YES/NO Fund name .....

Are you covered by Veteran Affairs? YES/NO File Number .....

How did you hear about us? Google Website Signage Health Insurance Health Engine

Yellow Pages Personal referral (please write their name below as we would like to thank them personally)

Occupation.....

Contact in the event of an emergency: Name .....

Phone no..... Relationship.....

Once an appointment is booked with us, we will consider this confirmed and will make a courtesy reminder via your preferred method, as nominated above. Please note, failure to attend or should 24 hours' notice of cancellation not be given, a fee will be charged. Without notice of cancellation we are unable to see another patient in need of our help. We appreciate your understanding in this regard.

MEDICAL HISTORY

Family Doctors/Specialist Name.....Phone No.....

When was your last medical check up?.....

Are you allergic to any of the following? : (tick)

Penicillin ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐

Ibuprofen ☐ Latex/rubber ☐ Other ☐ .....

Please list any medication taken on a regular basis .....

Are you taking Aspirin/Blood Thinners/Anticoagulants?.....

Have you ever had Botox or dermal filler before Yes ☐ No ☐

Are you taking bisphosphonate medication or any other medication to treat osteoporosis? Yes ☐ No ☐

Do you have , or have ever had , any of the following medical conditions ? (Please answer every question)

Heart problems	Yes ☐	No ☐		Emphysema	Yes ☐	No ☐	
Kidney disease	Yes ☐	No ☐		Cardiac pacemaker	Yes ☐	No ☐	
Cancer/Leukaemia	Yes ☐	No ☐		Diabetes	Yes ☐	No ☐	
Heart surgery	Yes ☐	No ☐		Tuberculosis	Yes ☐	No ☐	
Hepatitis- type :	Yes ☐	No ☐		Heart Valve Disorder	Yes ☐	No ☐	
Chemotherapy	Yes ☐	No ☐		Eating disorder	Yes ☐	No ☐	
Heart murmur	Yes ☐	No ☐		Epilepsy	Yes ☐	No ☐	
HIV /AIDS	Yes ☐	No ☐		Artificial heart valve	Yes ☐	No ☐	
Radiation therapy	Yes ☐	No ☐		Osteoporosis	Yes ☐	No ☐	
Rheumatic fever	Yes ☐	No ☐		Arthritis	Yes ☐	No ☐	
Jaundice	Yes ☐	No ☐		Artificial prosthesis	Yes ☐	No ☐	
Thyroid disease	Yes ☐	No ☐		Anaemia /blood disorder	Yes ☐	No ☐	
High blood pressure	Yes ☐	No ☐		Severe headaches	Yes ☐	No ☐	
Low blood pressure	Yes ☐	No ☐		Asthma	Yes ☐	No ☐	
Steroid therapy	Yes ☐	No ☐		Neurological disorder	Yes ☐	No ☐	
Ulcer/stomach disorder	Yes ☐	No ☐		Gastric Reflux	Yes ☐	No ☐	
Prolonged bleeding	Yes ☐	No ☐					
Cholesterol	Yes ☐	No ☐					

Are you a smoker? Yes ☐ No ☐ How many per day?.....

Are you pregnant? Yes ☐ No ☐ When is your due date? .....

Is there anything else you feel we should know about your medical history? Yes ☐ No ☐

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DENTAL HISTORY

Your previous dentist/practice name .....

When was your last dental check up? ..... When did you last have dental xrays?.....

How do you feel about dental treatment ? Calm ☐ Apprehensive ☐ Anxious ☐ Fearful ☐

What is the purpose of your visit today? .....

Have you ever had orthodontic work? If yes when?..... Yes ☐ No ☐

Have you ever had difficulty with dental anaesthetic ? Yes ☐ No ☐

Have you had any oral surgery, eg. wisdom tooth removal? Yes ☐ No ☐

Have you had any complications during or after dental treatment? Yes ☐ No ☐

Have you bleached / whitened your teeth? If yes when?..... Yes ☐ No ☐

Have you had prolonged bleeding or infection after having a tooth removed ? Yes ☐ No ☐

Are you happy with the appearance of your teeth? Yes ☐ No ☐

Is there anything you would like to change about your teeth or their appearance?

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Are your teeth sensitive to: heat ☐ cold ☐ biting ☐ pressure ☐ sweets ☐

Do you floss? Yes ☐ No ☐ How often? .....

Do your gums bleed when you brush and /or floss? Yes ☐ No ☐

Does food catch in between your teeth? Yes ☐ No ☐

Do you grind your teeth or clench your jaws? Yes ☐ No ☐

Have you been diagnosed with TMD? Yes ☐ No ☐

Have you worn a bite appliance / nightguard/ splint / snoring device ? Yes ☐ No ☐

Have you been diagnosed with gum / periodontal disease? Yes ☐ No ☐

If so, who is your periodontist? .....

I have completed this questionnaire to the best of my knowledge, understanding that failure to make a full disclosure may place me at undue medical risk. I understand that notes, radiographs and models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give permission for the practice to use the above contact details to send me appointment and check-up reminders.

Signature :.....Date :.....

Dentists Signature .....

NOTICE FOR PATIENT INFORMATION

Your Health Information and Our Privacy Policy

Our practice respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles. This statement is a brief summary of the practice's privacy policy. The complete policy is available on request.

Our practice trading as Hampton Dental Centre collects information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are 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 health care. We may collect information about you from third parties providing the collection of that information is necessary to provide you with health care.

We may disclose your health information to other health care professionals, or require it from them if, in our judgement, it is necessary in the context of your care.

We may also use parts of your health information for research purposes, in study groups or at seminars; however, in such situations, your personal identity will not be disclosed without your consent.

If you choose not to provide us with information relevant to your care, we may not be able to provide a service to you, or the service we are asked to provide may not be appropriate for your needs. Importantly, if you do not provide information that may be relevant to your care or that is otherwise requested by us, you could suffer some harm or other adverse outcome.

Your medical history, treatment records, x-rays and any other material relevant to your care will be stored by the practice. The practice privacy policy sets out how you can access your records or seek correction of your records.

The practice privacy policy sets out how you may complain about a breach of privacy and how the practice will deal with such a complaint.

As part of its electronic records system, the practice may rely on cloud storage providers located outside Australia. The practice will ensure that any offshore transfer complies with its obligations under Australian privacy laws.

The practice Privacy Officer can be contacted at the practice during business hours if you have any concerns or questions about a privacy matter.

Do you give consent for messages to be left with family members or on an answering machine regarding treatment or appointments? Please circle YES NO

Signature _____

Date: _____

PAYMENT IS REQUIRED ON THE DAY OF TREATMENT