SHIRE DENTAL
CENTRE

Medical and Dental History (confidential)

Contact Details

Surname ……First Name …… Title (Mr, Mrs, Miss, Mstr, Dr) ……..

Preferred name …….. Date of Birth: ……

Address …… P/Code……

Postal address (if different from above) ……..

Telephone (H) …… (M) …… (Email) ……

Occupation …… Work Phone ……

Emergency Contact …… Relationship to patient…….. Telephone ……

Shire Dental Centre bulk bills services under the CDB Scheme or with a valid DVA Gold or White Card.
Shire Dental Centre offers 10% discount to holders of Seniors card or Age Pension card

☐ For children 2 – 17 bulk billing under CDBS Medicare No. __ __ __ __ __ __ __ __ __ __ __ seq __

☐ I have Health Insurance for Dental Cover Health Fund ……..
(Bupa / HCF / NIB / AHM / Medibank / Teachers)

☐ I am a Veterans Affair Gold or White card holder Member no. __ __ __ __ __ __ __ __

Please complete if the patient is under 18 years of age Parent / Guardian

Name…… Relationship to patient ……

Address …… Postcode ……

Telephone: Home …… Mobile ……

How did you hear about Shire Dental Centre?

Facebook Google Internet Letterbox drop Yellow pages Advertisement Referral

Name of patient who referred you to our practice: _____

Dental History

When was your last visit to a Dentist? …… Reason ……

What is the reason for your visit today? ☐ Routine check-up /clean ☐ Emergency treatment

☐ Continue unfinished treatment ☐ Second opinion ☐ Other (specify)……..

Are any of your teeth sensitive to:		**Do your gums hurt or bleed?**	Yes / No
Hot/Cold	Yes / No	Have your parents experienced gum disease or tooth loss	Yes / No
Sweets	Yes / No	Have you noticed loose teeth	Yes / No
Biting or chewing	Yes / No	Have you noticed bad breath or a bad taste in your mouth	Yes / No

Are you interested in:		**Do you?**	
Teeth whitening	Yes / No	Clench or grind your teeth	Yes / No
Teeth straightening	Yes / No	Have clicking or popping of your jaw	Yes / No
Dental implants	Yes / No	Have difficulty or pain with opening your mouth	Yes / No

Does dental treatment make you nervous? ☐ No ☐ Yes ☐ Extremely

If dental treatment makes you nervous have you considered Nitrous Oxide (happy gas)? ☐ No ☐ Yes

Medical History

Name of GP …….. Suburb……

Are you receiving any medical treatment at present? ☐ Yes Details ……
Have you ever been hospitalised? ☐ Yes Details ……..
Have you had Heart of Joint Replacement surgery? ☐ Yes Details ……
Have you stopped taking any medications in the last week? ☐ Yes Details ……..
Are you allergic to any medication or antibiotics? ☐ Yes Details ……..
Are you allergic to LATEX? ☐ Yes Details ……..
Are you taking any medications at present? ☐ Yes Details ……..

……

Please ☑ if you have ever had any of the following?

Heart (surgery/disease/attack) ☐
Chest pain ☐
Congenital heart disease ☐
Rheumatic fever ☐
Heart murmur ☐
Mitral valve prolapsed ☐
Heart pacemaker ☐
High blood pressure ☐

Asthma ☐
Emphysema ☐
Chronic cough ☐
Tuberculosis ☐

Latex sensitivity ☐
Sinus problems ☐
Hay fever ☐

Diabetes ☐
Glaucoma ☐
Kidney problems ☐
Stomach problems ☐

Arthritis ☐
Artificial joints ☐
(Hip/knee etc) ☐

Liver disease ☐
Bleeding disorder ☐

Epilepsy/Seizures ☐
Stroke ☐
Neurological disorder ☐
Fainting/Dizzy spells ☐

Cancer ☐
Type: _____
Radiotherapy ☐
Chemotherapy ☐

Infectious disease ☐
HIV/AIDS ☐
Hepatitis ☐
Creutzfeldt Jakob Disease (CJD) ☐

Do you have any other condition not listed? Yes / No If yes, please list

……..

Name of Specialist …… **Suburb**……

Female patients: Are you pregnant? ☐ No ☐ Yes If yes, how many months? ……..
Are you on oral contraceptives? ☐ No ☐ Yes
Nursing ☐ No ☐ Yes

Smokers: How many cigarettes do you smoke per day?..... Would you like to stop? ☐ Yes

Privacy and Payments

The information collected by our practice will be used for the purpose of providing treatment to you. Personal information may be used to address accounts to you, process payments and write to you about our services or any issues affecting your treatment. Payment is required on the day of treatment unless otherwise arranged. Cash, EFTPOS and credit cards (Mastercard, Visa, AMEX) accepted. No fee is charged for credit card use. Private health insurance claims are processed on the spot using the HICAPS terminal. In the event where your overdue account is referred to a collection agency and/law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge all the preceding information is true and correct. If any further information is needed you have permission to contact my health care provider, who may release information to you. If there are any changes in my medical history I will inform my dentist at the next appointment.

Patient Signature…… **Date** ……