# thedentalroom

**Welcome to our practice**. In order to provide you with the highest level of care and consideration, please take the time to answer these questions completely.

## PERSONAL INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

First Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: _____

Street Address: _____ Postcode: _____

Email Address: _____

Home Phone: _____ Mobile: _____

Postal Address (if different to above): _____

Name of person responsible for fees: _____

Address (if different to above): _____

Emergency Contact Name & Number: _____ Relationship: _____

Please tick if applicable ☐ I have private health insurance with dental cover ☐ I have a veterans card

How did you discover our practice?

☐ Facebook ☐ Instagram ☐ Social Influencer/s ☐ Google ☐ Practice Signage

☐ Personal recommendation by _____ ☐ Others _____

## MEDICAL INFORMATION

Physician's Name: _____ Telephone: _____

(Woman) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you had any of the following? (please tick)

☐ Arthritis/ Rheumatism
☐ Artificial joints (knee, hip, etc.)
☐ Asthma
☐ Blood Pressure: High / Low
☐ Cancer, Tumour or other malignancy
☐ Chest Pain
☐ Congenital Heart Disease
☐ CJD: High / Low Risk
☐ Diabetes
☐ Disability (physical or developmental)
☐ Emphysema or other lung disease
☐ Epilepsy
☐ Excessive Bleeding or blood disorder
☐ Heart Ailment (heart attack, coronary artery disease, cardiac surgery)
☐ Heart Murmur
☐ Hepatitis or Liver disease
☐ HIV / AIDS
☐ Kidney Disease
☐ Osteoporosis or other bone disorder
☐ Radiation or Chemotherapy
☐ Rheumatic Fever
☐ Special Needs (Autism, Developmental Delay etc.)
☐ Stroke or other CVA
☐ Tuberculosis

Have you had any other previous illnesses? ☐ Yes ☐ No (please list) .....

Have you ever been advised to take antibiotics before dental treatment? ☐ Yes ☐ No

List medications you are currently taking: .....

.....

Allergy to Penicillin, Aspirin or Other Drugs: ☐ Yes ☐ No Specify: .....

Allergy to Latex product or Rubber gloves: ☐ Yes ☐ No

## DENTAL INFORMATION

Reason for today's visit: .....

Former Dentist: ..... Approximate date of last dental visit: .....

Please tick if the following are a concern for you:

- ☐ Breath Issues
- ☐ Broken fillings / Cracked teeth
- ☐ Blisters / Ulcers
- ☐ Cosmetic improvement
- ☐ Clench / Grind Teeth
- ☐ Dry Mouth
- ☐ Food Collection between teeth
- ☐ Gums swollen, tender or bleeding
- ☐ Loose tooth
- ☐ Orthodontics (braces) / Invisalign
- ☐ Missing teeth
- ☐ Mouthguards
- ☐ Sensitivity to pressure or irritants (cold, hot or sweets)
- ☐ Sleep Apnoea
- ☐ Snoring
- ☐ TMJ
- ☐ Toothache
- ☐ Tooth Replacement Options (denture, crowns, bridges, implants)
- ☐ Wisdom teeth
- ☐ Zoom teeth whitening
- ☐ Others (indicate): .....

How often do you brush? ..... How often do you floss? .....

Have you ever had an allergic reaction or allergic symptoms to local or general anaesthetics? ☐ Yes ☐ No

Have you had trouble from previous dental care? ☐ Yes ☐ No

## YOUR HEALTH INFORMATION & PRIVACY POLICY

The information collected above will be used for the purpose of providing the best treatment to you. Personal information will be used to address account to you, process payments and write to you about our services. With your consent, we may disclose your health infromation to other health care professionals, or require it from them if it is necessary in the context of your treatment.

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 anytime. Fees may apply.

## DIGITAL / SOCIAL MEDIA POLICY

Photos and videos taken at the clinic may be published for lawful purposes on The Dental Room's social media channels and other digital platforms, including for example such purposes as publicity, illustrations, advertising and digital content. Please do not hesitate to raise any concerns you may have with our practice and/ or if you wish to opt-out from this.

## CLIENT CONSENT

I have completed this document as thoroughly as possible. I understand that my failure to disclose all health related information may place myself at risk.

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

I have also read and understood The Dental Room Policy, and consent to the use of my infromation in this way.

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

**Thank you for your assistance and welcome to The Dental Room.**