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	
MOBILE No	Other Contact No	
PRIVATE HEALTH FUND-dental extras (yes or no)	Fund Name & Mem No	
MEDICARE CARD No - -	ID No ON CARD	EXPIRY DATE /
GENDER	NATIONALITY	

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

NEXT OF KIN / EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE No

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 *(specify)*_____
☐ Rheumatic Fever
☐ Bone Disease (Pagets)
☐ Osteoporosis or Arthritis *(circle)*
☐ Cancer *(specify)*_____
☐ HIV / AIDS
☐ Hepatitis *(specify)*_____
☐ Diabetes *(specify)*_____
☐ Are you, or could you be pregnant ?

☐ Liver or Kidney Disease *(specify)*_____
☐ Asthma
☐ Epilepsy
☐ Nervous or Eating Disorder *(specify)*_____
☐ Joint Replacement *(specify joint & when)*_____
_____
☐ Sleep Apnoea
☐ Reflux
☐ Current Smoker *(how many per day?)*_____
☐ Previous Smoker *(when did you quit?)*_____
☐ Recent Surgery or Other Condition *(please note)*
_____

Who is your GP or Clinic ?	Phone No

List any Allergies - E.g.: Local Anaesthetic, Latex, Penicillin, Peanuts, etc *(please specify)*
_____

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 all 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 ☐ 3 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
☐ Worn / Broken Teeth
☐ Lost Filling / Cavity
☐ Grinding / Clenching Teeth
☐ Difficulty Chewing
☐ Pain in Face or Jaw Joints
☐ Sounds from Jaw Joint
☐ Discoloured Teeth
☐ Would like a whiter smile
☐ Bad Appearance of Teeth
☐ Would like a smile makeover

HOW DID YOU HEAR ABOUT US?

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

I accept the ultimate responsibility for payment of all dental treatment carried out on myself, and may include 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_____