BUNDOORA DENTAL CLINIC
Patient Information Record

GENTLE DENTAL CARE
FOR FAMILIES & INDIVIDUALS

Welcome to Bundoora Dental Clinic

To assist us in providing the best dental treatment for you, please answer the following questions as completely as possible.

PERSONAL INFORMATION

First Name: Mr Mrs Ms Dr _____ Surname: _____

Preferred Name: _____ Date of Birth: _____

Street Address: _____

Suburb/Town: _____ Postcode: _____

Telephone (Home): _____ Mobile: _____

Telephone (Work): _____ Email: _____

Occupation: _____ Employer: _____

Employer Address: _____

Name of person responsible for fees: _____

Address: (if different from above) _____

MEDICAL INFORMATION

Name of Medical Doctor: _____

Medical Practice Address: _____ Postcode: _____

Telephone: _____ Email: _____

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
- ☐ 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) _____

Would you prefer to discuss these in private with the Dentist? Yes/No _____

Are you pregnant? Yes/No Due date (if expecting): _____

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

Are you presently under medical care or taking any prescribed medicines or tablets? Yes/No (please list)

_____

Please list any medicines or products you are allergic to: (eg. Penicillin, Latex) _____

Do you have any other allergies? Yes/No (please list) _____

Are you currently taking any other non-prescription medication? Yes/No (please list) _____

_____

Please turn overleaf for Dental Information

Dental information

To assist us in providing the best dental treatment for you, please answer the questions relevant to you.

Who referred you to our dental practice? _____

Did you discover our practice through ☐ Yellow Pages ☐ Word of mouth ☐ Practice signage ☐ Advertising ☐ Website

What is your reason for today's visit? _____

What year was your last dental visit? _____ When was your last dental clean? _____

Have you ever had dental x-rays? Yes/No If yes, when were your last x-rays? _____

What dental work was performed at your last visit? _____

Previous dentist's name: _____

Previous dental practice address: _____

Are there any other dental problems that concern you? _____

Are you experiencing any discomfort? (please explain): _____

Are your teeth sensitive to ☐ Hot or cold ☐ Sweets ☐ Biting or chewing ☐ N/A

How often do you brush your teeth? _____

How often do you floss? _____

Do you use other forms of plaque control? Yes/No (If yes, please list) _____

Do you use a fluoride supplement? Yes/No (If yes, please list) _____

Are you aware of bad breath or a bad taste in your mouth? Yes/No _____

Do you clench or grind your teeth while awake or asleep? Yes/No _____

Have you had a splint made to prevent grinding or clenching? Yes/No _____

Do you have difficulty chewing on either side of your mouth? Yes/No (If yes, which side of the mouth) _____

Do you have soreness in your jaw joints, or pain in the sides of your face? _____

Do you experience clicking or cracking of your jaw joints or have experienced locking of your jaw? _____

Do you have headaches, neckaches or shoulderaches? _____

Do you drink tea or coffee or smoke cigarettes? _____

Are you satisfied with the appearance of your teeth? Yes/No _____

Would you like to change the appearance of your teeth? Yes/No How? _____

Would you like to make your teeth whiter or straighter? _____

Do you wish to replace your amalgam fillings with tooth coloured restorations? _____

Do you feel that you need to close spaces or replace missing teeth? _____

Would you like to keep all your teeth for all of your life? _____

What is the most important thing to you about your smile? _____

Do you have dental insurance? Yes/No (please circle) Name of fund: _____

NOTICE TO INSURED PATIENTS REGARDING DENTAL BENEFITS INSURANCE.

Item numbers on our statement represent as accurately as possible the procedures performed but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures, to attract refunds, and the rates of those refunds, are determined by the conditions of the patient's Health Insurance Policy. We accept no responsibility to either party, for any decision the Insurer may make regarding the refund of monies to the patient.

Patient declaration

I have completed the above questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place ME at undue medical risk. I have been issued a copy of the Bundoora Dental Clinic Privacy Policy and consent to the use of my health information in this way.

Signed: _____ Print Name: _____ Date: _____

Dependants: _____

Thank you for your assistance. Please advise us of any changes to the above information before future treatment.

1st Floor, 47 Plenty Road, Bundoora 3083 Telephone: (03) 9467 3733 Facsimile: (03) 9467 3066 Internet: www.bundent.com.au