Palmerston Dental Surgery

Phone: (08) 8932 1544

Suite 4, 6 Maluka Drive, Palmerston, NT 0830

www.palmerstondentalsurgerynt.com.au

Welcome to our Practice

Please answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Patient details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other ______

Surname: ______ Given name: ______ D.O.B: ______

Residential address: ______

Suburb: ______ State: ______ Postcode: ______

Postal address (if different): ______

Home phone: ______ Work phone: ______ Mobile: ______

Email: ______

☐ We may send out email communications to you from time to time, including appointment reminders and our regular newsletter. If you are happy for us to do so, please indicate your agreement by ticking this box.

Occupation: ______ Employer: ______

Private health insurer: ______ Member #: ______ Patient #: ______

Medicare #: ______ Vets Affairs #: ______ Expiry: ______

Emergency contact: ______ Phone: ______ Relation: ______

GP name: ______ GP phone: ______

GP address: ______

Preferred method of communication

☐ Email ☐ Letter ☐ SMS ☐ Telephone

Medical history

☐ Abnormal bleeding
☐ Angina
☐ Artificial heart valve
☐ Asthma
☐ Blood pressure (high/low)
☐ Blood thinner
☐ Bone disease
☐ Cancer
☐ Cardiac surgery/pacemaker
☐ Congenital heart defect
☐ Diabetes type 1/type 2
☐ Epilepsy
☐ Excessive bleeding
☐ Heart disease
☐ Heart murmur
☐ Hepatitis A/B/C/D
☐ HIV positive
☐ Immune deficiency
☐ Kidney/liver disease
☐ MS
☐ Nervous disorder
☐ Oral ulceration
☐ Prosthetic joints
☐ Psychiatric care
☐ Radiation/chemotherapy
☐ Reflux
☐ Rheumatic fever
☐ Steroid therapy
☐ Stroke
☐ Thyroid disorder

Are you pregnant? ☐ Yes ☐ No If so, due date? ______

Are you Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Are you taking medication (including natural supplements)? If yes, please list: ______

______

Are you a smoker? ☐ Yes ☐ No If yes, how often? ______

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Allergies

☐ **Yes** ☐ **None**

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs

☐ Other (please specify): ____________________

Dental history

Last dental visit: ____________

Have you ever had a reaction or complication following dental treatment in the past? ☐ Yes ☐ No

If yes, please detail: ____________________

Do you have any private or confidential information you wish to discuss in private and not write down?

☐ Yes ☐ No

Are you suffering from any of the following?

☐ Bad appearance of teeth
☐ Bad breath
☐ Bleeding gums
☐ Difficulty chewing
☐ Discoloured teeth
☐ Dry mouth
☐ Grinding/clenching teeth
☐ Missing teeth
☐ Loose teeth
☐ Lost filling/cavity
☐ Rapidly decaying teeth
☐ Pain in face/jaw
☐ Sensitive teeth
☐ Sounds from joint
☐ Toothache
☐ Unsatisfactory denture
☐ Worn or broken teeth

Have you ever had a sleep study and been diagnosed with sleep apnoea? ☐ Yes ☐ No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? ☐ Yes ☐ No

Has anyone ever told you that you snore? ☐ Yes ☐ No

After 6-7 hours of sleep do you wake up refreshed? ☐ Yes ☐ No

How did you find out about us?

☐ Google/website ☐ Yellow pages ☐ Dental Care Network ☐ Radio ☐ Signage

☐ Other (please specify): ____________________

☐ Referred by friend/family ____________________

On a scale of 1 – 10, with 10 being very comfortable and not at all anxious, how comfortable are you feeling about your appointment today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Privacy policy & signature

Any information is collected and maintained in accordance with State and Federal Privacy Legislation. A copy of our privacy policy can be obtained online at www.bupadental.com.au/privacy-policy.
I have accurately completed this medical history form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff.
I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

I authorise my dentist to take images of my teeth both before and after my treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.

Patient name: ____________ Signature: ____________ Date: ____________