PARADISE dentistry

Dental Practice QIP Quality Innovation Performance ACCREDITED

CONFIDENTIAL PATIENT INFORMATION REPORT

PERSONAL DETAILS

PLEASE CIRCLE: Dr Mr Mrs Miss Ms Mx Other: _____

SURNAME: _____ FIRST NAMES: _____

PREFERRED NAME: _____ DATE OF BIRTH: _____

PRIVATE ADDRESS: _____

MAILING ADDRESS: _____

HOME PHONE: _____ MOBILE: _____ WORK: _____

EMAIL: _____

PREFERRED METHOD OF CONTACT: _____

OCCUPATION: _____ LOCATION: _____

DOCTOR: _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE FUND: _____ MEDICARE NUMBER: _____

NEXT OF KIN (NOT AT SAME ADDRESS): _____

ADDRESS: _____ CONTACT PHONE: _____

DEAR PATIENT – PLEASE NOTE

You will receive a confirmation message 3 days prior to an appointment, please confirm with us. A cancellation within 24 hours will be considered a late cancellation and may incur a cancellation fee.

All personal information supplied will not be used for any promotional purposes.

PLEASE NOTE TREATMENT MUST BE PAID FOR AT EACH VISIT

Please tick if one of the following is applicable:

◯ Oral Health Service - Voucher ◯ Medicare - Child Dental Benefit Scheme

◯ Department of Veteran Affairs – Card Number _____

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MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
ARTIFICIAL JOINT			EXCESSIVE BLEEDING		
PLEASE SPECIFY:			HEART TROUBLE		
ANAEMIA			PLEASE SPECIFY:		
ASTHMA			HEPATITIS		
BLOOD PRESSURE: HIGH or LOW			HIV (AIDS)		
CANCER			HYPERTHYROIDISM		
PLEASE SPECIFY:			PSYCHIATRIC TREATMENT		
			REFLUX		
DIABETES: TYPE 1 TYPE 2			RHEUMATIC FEVER		
DRY SOCKETS			STROKE		
EPILEPSY			TUBERCULOSIS		

DO YOU HAVE ANY OTHER CONDITION YOUR DENTIST SHOULD KNOW ABOUT?

_____

ARE YOU ALLERGIC TO ANYTHING? ◯ YES ◯ NO

DETAILS: _____

ARE YOU PREGNANT? ◯ YES ◯ NO APPROXIMATE DUE DATE: _____

HAVE YOU TAKEN ANY MEDICATIONS OR SUPPLEMENTS IN THE PAST YEAR? ◯ YES ◯ NO

IF SO, PLEASE STATE: _____

_____

DO YOU SMOKE? ◯ YES ◯ NO HOW MANY PER DAY? _____

DO YOU DRINK TEA OR COFFEE? ◯ YES ◯ NO HOW MANY PER DAY? _____

DO YOU DRINK ALCOHOL? ◯ YES ◯ NO HOW MANY PER DAY? _____

DO YOU DRINK SOFT DRINKS? ◯ YES ◯ NO HOW MANY PER DAY? _____

DO YOU USE RECREATIONAL DRUGS? ◯ YES ◯ NO HOW MANY PER DAY? _____

HOW MUCH WATER DO YOU DRINK PER DAY? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS YOUR TEETH? _____

WHO TAUGHT YOU HOW TO BRUSH? _____ WHO TAUGHT YOU HOW TO FLOSS? _____

SHOULD I CHOOSE TO FOLLOW THE ADVICE OF THE ATTENDING DENTIST THEN I HEREBY GIVE CONSENT TO UNDERGO TREATMENT.

SIGNATURE: _____ DATE: _____ ATTENDING DENTIST: _____

(If under 18 years of age please have legal guardian sign)