PATIENT DETAILS & MEDICAL HISTORY

(MR / MRS / MS / MISS / MST / DR)

NAME: ______________________________ DOB: ______________

ADDRESS: ______________________________

PHONE: H: ______________ W: ______________ M: ______________

EMAIL: ______________________________ OCCUPATION: ______________

PERSON RESPONSIBLE FOR FEES: ______________ PRIVATE HEALTH INSURANCE (DENTAL): ______________

EMERG CONTACT: ______________ RELATIONSHIP: ______________ PHONE: ______________

MEDICAL DOCTOR: ______________ PH NO: ______________

HOW DID YOU HEAR ABOUT US? ☐ Signage ☐ Google ☐ Social Media ☐ Personal (who can we thank for referring you?) ______________

Have you had any of the following? (Please Tick)

Heart Problems or Circulatory Problems ☐ Blood Pressure ☐ Artificial Joints ☐ Tumour History ☐

Liver or Kidney Problems ☐ Asthma ☐ Epilepsy ☐ Ulcers (stomach) ☐

Blood Disorders or Anaemia ☐ Diabetes ☐ HIV ☐ Hepatitis **A B C D** ☐

Excessive bleeding or Bruising ☐ Sinus Trouble ☐ Covid Vaccination Status ______________

Do you Smoke? Y N **Female Patients: Are you pregnant? Y N**

Why have you come to the dentist today? ______________________________

Are you currently in pain? ☐ Do your gums bleed? ☐ How many times a day do you brush? ______________

Have you ever had problems with previous dental treatment? ☐ Please explain: ______________________________

How long has it been since your last dental visit? ______________

Are you allergic to any of the following? Latex ☐ Penicillin ☐ Codeine ☐ Others: ______________________________

Are you currently taking any drugs or medicines? ☐ Please list: ______________________________

Have you ever taken medication for bone cancer or Osteoporosis? ☐ Please list: ______________________________

Is there anything else you would like to discuss with us? ______________________________

CONSENT FOR TREATMENT

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make thorough diagnosis.
2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetics agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.
5. Any treatment recommendations are made on what is best for you, our patient: treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay.
6. All information will be held in confidence according the Privacy Act 1988.
7. Do you allow Sparkle Dental Care to contact you by e-mail for further correspondence informing clinic updates and promotions?

Patient/Parent Signature:

______________________________ **Date:** ______________

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www.sparkledentalcare.com.au