Pacific Smiles Dental

nib Dental Care

Patient details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Date of birth _____ Your occupation _____

First name _____ Surname _____ Preferred name _____

Residential address _____ Postcode _____

Postal address _____ Postcode _____

Phone number _____ Email _____

Health fund for dental cover _____ Membership number _____ Reference ID _____

Medicare number _____ Reference ID _____ Vet Affairs number _____

Emergency contact person _____

Phone number _____ Relationship to patient _____

Medical practitioner _____ Phone number _____

Are you of Aboriginal and/or Torres Strait Islander origin? (Please tick one option)

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Prefer not to say

Person responsible for account

Must be completed if patient is under 16, if same as above please tick here ☐

Name _____

Phone number _____ Relationship to patient _____

Address _____ Postcode _____

If third party, insurance company/employer responsible for account _____

Medical questions – private and confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/current medical conditions

List all current medications (prescription, over the counter, supplements, herbal)

_____

_____

_____

Please give details if you answer yes to any of the questions below

Are you receiving any medical treatment at present? ☐ No ☐ Yes _____

Are you allergic or had a reaction to any medications/tablets/ antibiotics or other? ☐ No ☐ Yes _____

Are you currently pregnant or breastfeeding? ☐ No ☐ Yes _____

Do you or have you smoked or vaped within the last 6 months? ☐ No ☐ Yes If yes, how many per day? _____

Do you drink alcohol? ☐ No ☐ Yes _____

Have you received treatment, injections, or tablets for bones, blood, or cancer therapy? ☐ No ☐ Yes _____

Continued over

Please indicate if you have **ever** had any of the following:

Any heart complaint / treatment	☐ No ☐ Yes	Hepatitis A,B or C	☐ No ☐ Yes
Tuberculosis	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes
Rheumatic fever or heart valve surgery	☐ No ☐ Yes	Jaundice or other liver diseases	☐ No ☐ Yes
Any nervous system disorder	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
High or low blood pressure	☐ No ☐ Yes	Transplanted organ or bone marrow	☐ No ☐ Yes
Gastric ulcer / digestive conditions	☐ No ☐ Yes	HIV or other blood borne viruses	☐ No ☐ Yes
Blood disorders	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes
Asthma / bronchitis / lung conditions	☐ No ☐ Yes	Steroid therapy	☐ No ☐ Yes
Anti-coagulant therapy	☐ No ☐ Yes	Depression / anxiety	☐ No ☐ Yes
Radiation therapy / chemotherapy	☐ No ☐ Yes	Sinus trouble	☐ No ☐ Yes
Joint replacement surgery	☐ No ☐ Yes	Kidney disease	☐ No ☐ Yes
Thyroid disease	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Osteoporosis or bone disease	☐ No ☐ Yes	Bisphosphonate medications	☐ No ☐ Yes

Dental history – private and confidential

Please give details if you answer yes to any of the questions below

When was your last dental examination and clean? _____

Are you currently experiencing pain or a specific dental problem? ☐ No ☐ Yes _____

Are you nervous, anxious or ever had a bad experience at a dental visit? ☐ No ☐ Yes _____

Do you have bleeding gums or have you ever been diagnosed with or treated for gum disease? ☐ No ☐ Yes

_____

How frequently do you brush your teeth? ☐ Once a day ☐ Twice a day ☐ Other _____

How frequently do you floss or use brushes to clean between your teeth? _____

Do you snore? ☐ No ☐ Yes _____

Do you experience jaw pain or clicking? ☐ No ☐ Yes _____

Have you been diagnosed with sleep apnoea or use a CPAP? ☐ No ☐ Yes _____

Is there anything you would like to talk to your dentist about that you are not comfortable writing on this form? ☐ No ☐ Yes

Would you like to discuss or find out more about any of the following:

☐ Replacement of missing teeth	☐ Tooth whitening	☐ Replacement of silver (mercury) fillings
☐ Cosmetic appearance	☐ Bad breath	☐ Dentures
☐ Removal of wisdom teeth	☐ Bleeding gums	☐ Implants
☐ Crowns	☐ Teeth clenching and grinding	☐ Orthodontics
☐ Veneers	☐ Root canal treatment	

Declaration

I agree that the above is a true and accurate record. I understand full payment on the day of treatment is required. Any expenses, costs or disbursements incurred by the Pacific Smiles Dental/nib Dental centre in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a non-refundable deposit requirement prior to future appointments being scheduled.

I have read and agree with the privacy statement provided to me.

Please note: This form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

☐ I do not consent to the use of my anonymised health information for research purposes for the improvement of future oral health in Australia. I understand that my choice to opt out will not affect the quality of care of service I receive.

Signature _____ Date _____

Please select the option that best describes how you found out about Pacific Smiles Dental/nib Dental:

☐ Referral from friend / family	☐ Health fund insurer	☐ Walk-in
☐ Google search	☐ Medical professional	☐ Existing patient
☐ HotDoc, Healthshare, Directories etc.	☐ Radio Ad	☐ Other (please specify)
☐ Social media (Facebook, Instagram)	☐ Pop Up/ Promo event	_____

The information recorded in this form, will be handled in accordance with the Pacific Smiles Dental Privacy Policy available at www.pacificsmilesdental.com.au or nib Dental Privacy Policy available at www.nibdental.com.au