Welcome To Shell Cove Dental

Personal & Contact Information

Surname: Mr / Mrs / Miss / Ms ______________________________ Other Names: ____

Date Of Birth: ______ / ________ / ________ Address: ____

Suburb: ____ State: ________________ Postcode: ____________________________

Phone: (H): _______________________ (W): __________________________ (M): ______________________________________

Email: ____Occupation:___________________________

Emergency contact person:

Name: ______________________________ Relationship to you: ____________________ Ph: ______________________________

Insurance & Payment Information

Do you have Dental Health Insurance? ☐ No ☐ Yes; Details - Health Fund Name: ______________________________

Health fund card number: __________________________________ Series number *(e.g. 01 or 2)* ______________________

If eligible for Child Dental Benefit Scheme: Medicare card number ______________________________ Ref: *(e.g. 1)* __________

Preferred method of payment? ☐ Eftpos ☐ Credit Card ☐ Cash

I understand that all Dental treatment must be paid for on the day. Signature: ___________________________

Medical History

Your Doctors Name: _______________________________________ Doctors Contact Number: _______________________________

Do you, or have you experienced any of the following Conditions? (Please tick all that apply)

☐ Prosthetic Heart Valve	☐ Joint Prosthesis	☐ Stroke
☐ Asthma	☐ Infective Endocarditis	☐ Bleeding Disorder
☐ Rheumatic Fever	☐ Kidney Disease	☐ Heart Pacemaker
☐ Diabetes	☐ Epilepsy	☐ Heart Murmur
☐ Tuberculosis	☐ High Blood Pressure	☐ Heart Attack/Angina
☐ Liver Disease	☐ Hepatitis	☐ HIV/AIDS
☐ Currently Pregnant	☐ Smoker	☐ Rheumatoid Arthritis

☐ Previous Surgery (Please Specify): ____

☐ Other (Please Specify): ____

☐ Allergies (Please Specify):____

☐ Details of Current Medications: ____

SHELL COVE
DENTAL

Dental History

How long since your last Dental Visit: ________________________ Who was your previous Dentist: ___________________________________

What did you like about your previous Dentist: ____

Why did you change: ____

Most important aspect of your teeth and what can we do for you today: ____

Are you having any discomfort or sensitivity: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

When did you last have dentals x-rays taken: ____

If you could change anything about your teeth what would it be:

☐ No Gaps ☐ Whiter ☐ More Even ☐ Longer ☐ Shorter ☐ Straighter

Are you or your partner aware of your clenching or grinding your teeth at night? ☐ Yes ☐ No

Do you wake up with aching jaws or teeth, with headache or stiff neck? ☐ Yes ☐ No

Do your gums ever bleed after brushing? ☐ Yes ☐ No

Do you have problems with bad breath? ☐ Yes ☐ No

Does food catch regularly between your teeth? ☐ Yes ☐ No

Do you have any teeth missing? ☐ Yes ☐ No

Do you have any bridges or dentures? ☐ Yes ☐ No

Have you heard about dental implants? ☐ Yes ☐ No

By Signing this form, I hereby agree that the information provided is true to the best of my knowledge. I understand that failure to make full disclosure may place me in undue medical risk and may compromise my dental treatment. I consent to any treatment agreed upon by the dentist and their staff and give permission to the treating practitioner to take any images of my teeth before and after your treatment for educational purposes. These images may be used in practise portfolio after gaining your consent and to show examples to other patients of dental work carried out within the practise (your identity will remain hidden).

Signature: ____ Date: ___________________________

Referral and Recall Information

How did you hear about us?

☐ Flyer in the mail ☐ Family or Friend (Name______________________) ☐ Yellow Pages

☐ Doctor (Name____________________________) ☐ Close to Home ☐ IHV ☐ Google search

☐ Facebook ☐ Website ☐ Other ______________________________

Would you like to be reminded every 6 months for a dental check-up? ☐ Yes ☐ No

If yes, would you prefer via Email ☐ Letter ☐ SMS ☐