Medical and Dental History (Adult)

Private and Confidential. Page 1 of 2.

Care For Smiles
Caring patiently and gently, always

Dr Rosemary Phillipos and her team welcome you to **Care For Smiles**. We assure you a caring and gentle environment and our complete attention to make your visit comfortable and relaxing. To assist in determining your treatment needs, please fill **both sides** of this form.

Contact Details

Surname ..... First name ..... Title .....

Preferred name ..... Date of Birth .....

Home address .....

Postal address (if different to above) .....

Email ..... Mobile ..... Phone .....

Occupation .....

Emergency contact ..... Relationship ..... Phone .....

Care For Smiles bulk-bills services under the Child Dental Benefits Scheme or with a valid DVA Gold or White Card. **Care For Smiles** offers 10% discount to holders of a Seniors or Carers card or Disability Pension (conditions apply).

If you have Health Insurance with Dental Cover: Health Fund ..... Member No. ..... Seq .....
(**Care For Smiles** is a preferred provider for the HCF and CBHS Health Funds)

For War Veterans holding a DVA Gold or White Card: Veterans' Affairs Card No. .....

Is a third party/insurance company/WorkCover/employer responsible for this account?

Details .....

How did you hear about Care For Smiles? .....

Your preference for appointment reminders? ☐ SMS ☐ Email ☐ Phone ☐ Other .....

Are there any personal/family situations that would make keeping your appointments difficult? ☐ No ☐ Yes

Dental Questionnaire

When was your last visit to a dentist? ..... Reason .....

Have you made this appointment for a ☐ Routine check-up / clean ☐ Continue unfinished treatment

☐ Emergency treatment ☐ Second opinion ☐ Other .....

Do you brush regularly? ☐ No ☐ Yes **Do you use a powered/electric toothbrush?** ☐ No ☐ Yes

Do you floss regularly? ☐ No ☐ Yes

Do you play sport? ☐ No ☐ Yes **Do you have a mouthguard?** ☐ No ☐ Yes

Have you ever had any of the following? (Please tick those that apply)

☐ Chipped or broken teeth? ☐ Wisdom teeth removed? ☐ Orthodontic treatment?

Are you concerned about or experiencing any of the following? (Please tick those that apply)

☐ Food trapping between your teeth ☐ Ability to eat ☐ Gaps or crowding

☐ Existing crowns, bridges or dentures ☐ Sensitivity to hot or cold ☐ Crooked teeth

☐ Grinding or clenching of teeth ☐ Oral hygiene ☐ Missing teeth

☐ Discolouration / Staining ☐ Bleeding gums ☐ Other .....

☐ Clicking/pain in jaw joints ☐ Bad breath ☐ Other .....

Does dental treatment make you nervous? ☐ No ☐ Yes ☐ Extremely Details .....

If dental treatment makes you nervous have you considered nitrous oxide (happy gas)? ☐ No ☐ Yes

Now, please fill Page 2 of this form

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Please answer these questions fully or discuss with the dentist.

Medical Questionnaire

Medical practitioner: Dr Name: .....Practice Name.....

Past / Present medical conditions. (Please tick those that apply)

Are you receiving any medical treatment at present?	☐ No ☐ Yes, Details .....
Have you had any serious or long standing illness?	☐ No ☐ Yes, Details .....
Have you ever been hospitalised?	☐ No ☐ Yes, Details .....
Have you had Heart or Joint Replacement Surgery?	☐ No ☐ Yes, Details .....
Have you stopped taking any medication in the last week?	☐ No ☐ Yes, Details .....
Are you allergic to any medication or antibiotics?	☐ No ☐ Yes, Details .....
Are you allergic to LATEX?	☐ No ☐ Yes, Details .....
Had cosmetic or other surgery to mouth, jaw, lips or face?	☐ No ☐ Yes, Details .....

Have you ever had any of the following? (Please tick those that apply)

☐ Anxiety / Depression	☐ Epilepsy	☐ HIV/AIDS
☐ Asthma / Breathing / Lung problems	☐ Excessive bleeding / bruising	☐ Osteoporosis
☐ Cancer (if so, where ……)	☐ Heart problems	☐ Rheumatic fever
☐ Diabetes	☐ Hepatitis / infectious diseases	☐ Pacemaker
☐ Digestive problems	☐ High blood pressure	☐ Other .....

Are you on any of the following medications? (Please tick those that apply)

☐ Blood thinning (Aspirin / Warfarin / Plavix)	☐ Cortisone (Prednisolone)	☐ Diabetes (Insulin, Diabex)
☐ Osteoporosis (Fosamax / Actonel)	☐ Thyroid (Thyroxin / Oroxin)	☐ Vitamins / Herbal Supplements
☐ Psychiatric (Anti-depressants / Lithium / Anti-anxiety / Sleeping tablets)		☐ Other .....

Female patients:	Are you pregnant?	☐ No ☐ Yes	How many months? .....
	Are you on oral contraceptives?	☐ No ☐ Yes	
Smokers:	How many cigarettes do you smoke per day?		Would you like to stop? ☐ Yes

Privacy Policy

Our Privacy Policy can be viewed on our website (www.careforsmiles.com.au/policies/privacy/). A copy is available at reception.

The information collected by our practice will be used for the purpose of providing treatment to you. Personal information may be used to address accounts to you, process payments, inform you about our services or issues affecting your treatment.

- We may disclose your health information to other health care professionals, or require it from them if it is necessary in the context of your treatment. Disclosure of your personal details will be minimised wherever possible.
- If necessary, we may pass information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies.
- Your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice without your prior written consent. If you have any queries or concerns please do not hesitate to raise these concerns with our practice.

Please note: Consultations/discussions incur a fee of $70/30min. For patients holding Private Health Insurance with Dental Cover, the fee can be rebated against Item Code 014 (consultation). Payment is required on the day of treatment unless otherwise arranged. Cash, EFTPOS and Credit Cards (American Express, Mastercard, Visa) are accepted. Private health insurance claims are processed on the spot using HICAPS. In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs. By signing this form, it is implicit you have read and understood these conditions.

Patient Signature ..... **Date** .....

Office Use:
Reviewed by _____