Shane Chambers Dental Prosthetics

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New Patient Information Form

According to Dental Practice Regulation 2004 under the Dental Practice Act 2001, for us to provide correct advice and safe treatment detailed personal and medical information is required. Please be assured that your information will be treated in strict confidence.

Personal Information

Title _____ Firstname _____ Lastname _____

Preferred Name _____ Date of Birth _____

Phone _____ Email _____

Preferred Method of contact: ☐ phone call ☐ text ☐ email

Do you want to receive appointment reminders by text message? ☐ Yes ☐ No

Street Address _____

Suburb _____ Postcode _____

PO Box Home: _____

Emergency contact: Name _____ mobile _____

How did you hear about us? _____

Your occupation: _____

Do you have Private Dental Health Insurance? ☐ Yes ☐ No Health Fund: _____

Are you eligible for DVA Dental Services? ☐ Yes ☐ No QSM No: _____

Medical Information

Please tick any past or current conditions or illnesses:

☐ autoimmune disorder ☐ arthritis ☐ asthma ☐ bleeding problem

☐ blood pressure problem ☐ chemotherapy/radiation ☐ cancer/tumour ☐ dementia

☐ depression/anxiety ☐ diabetes ☐ dizziness/fainting ☐ epilepsy ☐ gastric reflux

☐ heart problem ☐ hepatitis B/C ☐ HIV/AIDS ☐ joint replacement

☐ kidney problem ☐ liver problem ☐ osteoporosis ☐ sinus problem ☐ stroke

☐ thyroid problem ☐ tuberculosis ☐ vascular problem

Any other illnesses/conditions not listed above?

_____

Have you ever taken or used Bisphosphonate/Denosumab for osteoporosis? ☐ Yes ☐ No

☐ Fosamax ☐ Alendro ☐ Actonel ☐ Skelid ☐ Aredia/Pamisol ☐ Aclasta

☐ Didrocal/Didronel ☐ Bonefos ☐ Prolia ☐ Zometa If yes, how long?_____

Are you taking or recently taken any medications, supplements, injections (eg: Actonel/Prolia) or any recreational drugs? ☐ Yes ☐ No

If yes, please list all or provide a copy of your medication list:

_____

Are you allergic to any medications or any dental materials (eg: latex, chlorhexidine)? ☐ Yes ☐ No _____

Have you ever been told that you need antibiotic cover for dental treatment? ☐ Yes ☐ No

Do you smoke cigarettes, tobacco or marijuana? ☐ Yes ☐ No

Is there anything else we should know medically about you that is not included above?

_____

Denture Information

Why do you seek denture care at this time? _____

Have you seen other dentists/dental specialists about this concern? ☐ Yes ☐ No

How long have you had this problem? _____

Have you had any problems or difficulties with previous denture treatments? ☐ Yes ☐ No

Are there any other dental concerns we should address for you today? ☐ Yes ☐ No

_____

Privacy Consent

The information collected will be used for the purpose of providing treatment to you.

1. Personal information will be used to address accounts to you, process payments and write to you about our services.
2. 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, in that event, disclosure of your personal details will be minimised wherever possible.
3. We may use parts of your information for research purposes as this may provide benefits to other patients. Should this happen your personal identity will NOT ever be disclosed.
4. Photographic records prior to, during and after treatment may be taken for educational purposes: case discussions and presentations.

Financial Consent

I am aware that full payment for treatment is required by cash, bank cheque, eftpos, visa or mastercard (unless alternative payment arrangements have been agreed upon prior to treatment).

If I have private dental health insurance, I am responsible for verifying availability of any rebates for dental prosthetic treatment. I am aware that the practice is not responsible for any amount I can or cannot claim.

I understand that at least 24 hours notice is required to reschedule an appointment or a cancellation fee may apply for failure to do so.

Signature _____ Date _____

EMAIL FORM