EAST RINGWOOD DENTAL CLINIC
PATIENT PRE-TREATMENT DETAILS

In order for us provide the highest standard of dental care, it is requested that you fill in this form carefully and thoroughly.

Surname………………………………………. Other Names:……………………………..…………….. Title: Mr Mrs Miss Ms Dr
Home Address:………………..…………………………………….……………………………….… P/Code:…………………….
Ph:……….…………………..….…Occupation: …………………………..…..……………………...………………………………
Business Address…………………...……………………………….……….. P/Code:…………….. BH Ph:………….……….…...
Date of birth:…………………….…..….. Email:…………….……………………..……….. Mobile……….…………………...…….
Emergency Contact…………….…………. Address:……………………………………...……. Phone:…………………………….
Medical Doctor…………………………….… Address:………………………………….………….Phone:……….……………………
Who recommended our practice to you?……………………………………………………………………………..…………….
Do you have dental insurance? Yes No which fund?…………………………..………………………………………

It is important that we be aware of any health issues as this may affect our treatment or the medications we use.
Have you ever had any of the following? (Please circle)

Rheumatic Fever	Yes	No	Hepatitis A B C (Circle)	Yes	No
Epilepsy	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Heart ailment	Yes	No
Tuberculosis	Yes	No	AIDS/HIV	Yes	No
Diabetes	Yes	No	Excessive Bleeding	Yes	No
Kidney disease	Yes	No	Frequent Headaches	Yes	No

Have you ever been hospitalized for any illness, operations etc? Yes No ……………………………………..………….
Have you ever had any problems with dental treatment? Yes No ………………………………………….………..
Are you currently under medical care or taking any medications? Yes No …………………………………….….……..
……..……..….……
Female patients, are you pregnant? Yes No weeks……………………..…...………..….
Are there medications or products you are allergic to? (e.g. penicillin, latex) Yes No ………………………………………….………….…
Would you like to discuss these questions in private with the dentist? Yes No …………………………….……….……
Do you have a particular reason for today's visit? ……………………………………………………………………..…………….…
How long since your last dental appointment? …………………………………………………………………...…………….
How often do you have dental examinations?...
Previous dental X-rays were taken: ☐ Less than a year ago ☐ longer than a year ago
Do you have any bone diseases? – Osteoporosis, Paget's disease, Cancer spread to bones, Multiple Myeloma or other bone conditions?………..
Are you taking any medications for these diseases? (e.g. Fosamax, Actonel, Zometa, Pamisol) Yes No…………………………..……

Have you ever had any of the following?

Does your jaw click or hurt?	Yes No	Do you smoke?	Yes No
Do you feel you grind your teeth?	Yes No	Do you think you have occasional bad breath?	Yes No
Have you ever had orthodontic treatment?	Yes No	Do your gums ever bleed when you brush your teeth?	Yes No
Do you wear a night guard?	Yes No	Do you experience sensitivity with hot/cold?	Yes No
Have you ever had gum disease?	Yes No	Does floss ever tear between your teeth?	Yes No
Have you ever had your bite adjusted?	Yes No	Does food get jammed between your teeth?	Yes No
Do you bite your cheek or lips often?	Yes No	Do your teeth ever hurt when you bite hard?	Yes No

Thank you for your assistance

Privacy Policy

Our practice respects our patient's rights to privacy. It is important that our patients understand why we collect details about your health, how this information is used at our practice and the circumstances under which it may be disclosed.

Patients should be assured that their private information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either the patient's treatment or the administration of the practice without written consent from the patient.

Our privacy policy

1. The information collected will be used for the purpose of providing quality dental treatment. Personal information such as patient's name, address and health insurance details will be used for the purpose of correspondence, as well as processing payments, writing to patients about our services and any issues affecting a patient's treatment.
2. This practice may disclose a patient's health information to another health care professional, or require it from them if, in our judgment, it is necessary in the context of a patients treatment.
3. This practice may use part of patient's health information for research purposes, in study groups or in seminars, as this may provide benefit to other patients. All information will be anonymous.
4. The dental history, treatment records, X-Rays and all other materials relevant to dental treatment will be kept on premises. Patients may inspect or request a copy of our records at any time. Statutory fees will apply in relation to the type of access sought. If a patient requests an explanation of our records from the dentist or a written summary, our usual fees will apply for these services.
5. If our information about a patient is inaccurate, the patient may ask us to alter our records accordingly.

Payment and Cancellation Policy

Payment is required on the day of treatment. If unable to attend, 24 hours notice is required otherwise a fee may be charged.

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk.

Signed: ………………………………………………………. Date: ……………………………………