Medical History - Channon Lawrence Dental

Information provided is completely confidential and is protected by the provisions of the Federal Privacy Law Legislation. Your assistance in completing our acquaintance form assists us to provide you with dental care of the highest standard.

MS MRS MISS MR MSTR Other_____
Surname: _____ Legal Name: _____

Preferred name: _____ DOB: _____-_____-_____

Address: _____

Home: _____ Bus: _____ Mobile: _____

Email Address: _____

What is your preferred method for us to contact you? Home / Work / Mobile / SMS / Email / Any

Occupation: _____ Employer: _____

Next of Kin: _____ Relationship: _____ Phone No: _____

Private Dental Insurer: _____ Reference # on Card: ____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Reference # on Card: ____ Expiry Date: ___/_____

How did you hear about our practice?

Billboard	Y / N	Gympie Today	Y / N	Social Media	Y / N
Google	Y / N	Word of Mouth	Y / N	Existing Patient	Y / N

Other: _____ If yes, please let us know who _____

Are there any matters of a confidential nature you wish to discuss in private? YES/NO

Medical History

Please tick the appropriate boxes -

Heart disease	☐	Hepatitis A, B or C	☐	Asthma	☐
High blood pressure	☐	Diabetes	☐	Epilepsy	☐
Low blood pressure	☐	Liver disease	☐	HIV/AIDS	☐
Other blood disorder	☐	Serious accident/illness	☐	Hospitalised in last 2 years	☐
Stroke	☐	Hyperthyroidism	☐	Kidney disease	☐
Cancer	☐	Nervous disorders	☐	Neck or back problems	☐
Allergy to medications	☐	Allergy to latex	☐	Smoker	☐

Allergies: _____

If nervous or anxious, how can we help make dental visits more enjoyable for you?

_____

Do you require antibiotic therapy for any condition prior to undergoing dental treatment?
ie; heart murmur or artificial hips/knees YES/NO
Are you currently taking medication to treat osteoporosis YES/NO
Ladies, is there a possibility you may be pregnant? YES/NO
Have you recently experienced cold/flu symptoms? YES/NO
Do you use a CPAP Breathing Device? YES/NO

Current medications and/or vitamins: _____
Name and contact of your Medical Practitioner or clinic: _____

Dental History

Is there anything in particular you wish to discuss with us today regarding your teeth?
If yes, details_____

Have you had problems with previous dental visits (e.g., with anaesthetic, etc.)?
If yes, what was your previous experience? _____
_____

Do you wear a partial or full denture? If so, how long have you worn your denture?
_____

How many times do you brush your teeth per day? Once Twice Three times

Do you floss? If yes, how often? _____

Does any of the following apply to you and your teeth?

Floss catches or shreds	Y / N
Do you play contact sport	Y / N
Gums bleed when brushing/flossing	Y / N
Do you have worn, chipped or jagged edges that bother you	Y / N
Have you been diagnosed with Periodontal Disease	Y / N
Do you have old fillings or other dental work that causes discomfort?	Y / N
Do you have spaces or gaps that bother you	Y / N
Do you like the colour of your teeth	Y / N
Do you grind your teeth	Y / N
How would you rate your smile 1 to 10	____
Does your jaw click	Y / N
Do you wake with sore/tired jaw	Y / N
Are you a mouth breather	Y / N

How would you improve your smile? (Colour, shape, length etc.)
_____
_____
_____

***** I understand that I am personally responsible for the payment of all dental services rendered. I acknowledge that payment is appreciated and expected on the day of treatment, unless prior arrangements have been made.***

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. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent between both ***Channon Lawrence Dental and Southside Smiles*** *to aid them in my treatment and I consent to this. I also give my permission for the practice to use the above contact details to send me appointment and preventative care recall reminders.*
I consent for my details to be used for the purposes outlined above: YES / NO

Patient Contact / Sharing of Patient Records Consent

At Channon Lawrence Dental we take your privacy seriously. From time to time, we would like to contact you with details of other dental services that we provide or introduce, such as additional clinics or introductory treatment offers. We also value your clinical records and know that it is important to offer you treatment as soon as required.
I consent for my details to be used for the purposes outlined above: YES / NO

Please read this Privacy Collection Statement to see how we use your personal information

Maven Dental Group Pty Ltd ACN 131 333 492 and its subsidiaries and related bodies corporate and our website www.mavendental.com.au collect, handle, use and protect your personal information in accordance with the *Privacy Act 1988* (Cth) and our Privacy Policy which can be viewed in full https://mavendental.com.au/privacy-policy. Or please ask our reception team for a copy of our Privacy Policy.

We collect your personal information to provide you with products and services you have requested, improve our products and services, keep you informed of your upcoming appointments and notify you about our latest promotions and other offers relevant to you. We collect this information mainly through our communications with you, but we may do so also from other sources in the course of providing our services to you. You are not obliged to provide us with your personal information, however this may impact our ability to provide you with our products and services. We generally do not disclose information about you to any person and will only share your personal information where necessary to provide you with products and services, as required by law, or with your permission. Our Privacy Policy sets out how you can access and change your personal information or make a privacy complaint.
If you would like us to send you a copy of our Privacy Policy, inform us that you do not wish to receive promotional material from us, request access to or the correction of information we hold about you or to make a complaint about our treatment of your privacy, please contact us by email at notices@mavendental.com.au by phone on +61 (07) 5635 2000 or by mail to The Privacy Officer, Maven Dental Group, PO Box 1146 SOUTHPORT BC QLD 4215.

First Name: _____ *Last Name:* _____

Signature: _____ *Date:* _____

NB: Patients under the age of 18 years must have this form signed by a Parent or Guardian.

Thank-you for assisting us in providing you with the highest level of care.