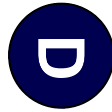

walshdental
Dr. Simon Walsh and associates

508 Glynburn Road
Burnside SA 5066
t.f. 8331 0436

smile make-overs
cosmetic dentistry
dental implants
crowns and bridges
porcelain veneers
dentures and same day repairs

**How did you hear about us?** (please tick)

- ☐ Internet
- ☐ Passing By
- ☐ website
- ☐ Flyer
- ☐ Health Fund
- ☐ Friend/Family…..................
- ☐ Norwood Football Club
- ☐ Bridgewater Football Club

## Personal Information

Title……………
Surname……………………………………………………………………………………..
Christian Names…………………………………………………………………………
Marital Status……………………………………..DOB………………………………...
Address…………………………………………………………………………
Post Code………………………Email……………………………………………………..
Telephone: (H)……………………..(W)………………………(M)……………...........

Occupation……………………………………………………………………………..
**Health Fund…………………………………………………………………………….**

If minor parents full name……………………………………………………………..
Person Responsible for account……………………………………………………..
Emergency Contact……………………………………..Phone………………………..
Health Fund……………………………………….................................................

General Practitioner…………………………………………………………………
Address………………………………………………………………………………
Phone Number…………………………………………………………………………

Name of Specialist (if applicable)…………………………………………………….
Address………………………………………………………………………………
Phone Number……………………………………………………………………

We request and expect payment at the time of treatment. For your convenience we accept cash, cheque, eftpos and all major credit cards.

I understand that payment of the account is my responsibility, and that my Health Fund (if any) will not cover the full amount. I undertake to pay the expenses incurred or to be incurred in the collection of any overdue portion of this account.

**Please provide 24 hours notice of a cancellation or a fee may be charged.**
**Late cancellation or non-attendance of any afterhours appointment (any appointment scheduled after 5pm) will attract a cancellation fee of $55.00 per ½ hour appointment.**

Signed……………………………………………………Dated………………………

## Dental History

Welcome to our practice. To help us evaluate your dental health please answer the following questions.

What is the reason for today's visit?......................................................................

How long since your last visit to a dentist? (approx)............................................

Have you ever had dental x-rays taken? If yes, when?.......................................................................................................

If wearing dentures, when were they constructed?................................................................................................

**WHAT DENTAL PROBLEMS DO YOU HAVE?** (please circle problems relevant to you)

| Tooth Ache | Y/N | Aware of grinding / Clenching | Y/N |
|---|---|---|---|
| Sensitive teeth to hot or cold | Y/N | Worn or Broken Teeth | Y/N |
| Sensitive teeth to biting pressure | Y/N | Clicking or noises in jaw joints | Y/N |
| Sensitive teeth to sweet | Y/N | Locking of jaw joints | Y/N |
| Problems with food impaction | Y/N | Pain in face or jaw joints | Y/N |
| Lost filling or cavity | Y/N | Suffer migraine or headaches | Y/N |
| Bleeding Gums | Y/N | Stiff or sore facial muscles | Y/N |
| Loose teeth / loose denture | Y/N | Trauma to face or head | Y/N |
| Missing teeth | Y/N | Eating is uncomfortable, painful, tiring | Y/N |
| Bad Breath | Y/N | Bad Appearance | Y/N |

Do you have any other dental problems?............................................................

Are you interested in improving your smile? Y/N
If yes, briefly state what you do not like about your smile…………………………...
…………………………………………………………………………………………..
In a previous dental visit have you ever had:

a) Abnormal reaction to drugs used by the dentist……………………………
b) Difficult extractions……………………………………………………………
c) Dry Sockets……………………………………………………………………
d) Excessive Haemorrage………………………………………………………

Private & Confidential

## Medical History

Have you had any serious health problems in the last year? Yes/No
Details…………………………………………………………………………………..

**Are you presently taking any drugs, medicines or tablets of any kind?**
**Please List……………………………………………………………………………**
……………………………………………………………………………………………
Are you taking: Antidepressants Y/N Blood Pressure Tablets Y/N

Have you ever had an unfavorable reaction to local or general anaesthetic? Y/N

**HAVE YOU EVER HAD ANY OF THE FOLLOWING?** (please circle)

| Congenital Heart Disorders | Y/N | Hyperthyroidism | Y/N |
|---|---|---|---|
| Heart Murmur | Y/N | Diabetes | Y/N |
| Heart Disease | Y/N | Allergy to penicillin | Y/N |
| Blood Pressure Problem | Y/N | HIV / AIDS | Y/N |
| Heart Bypass | Y/N | Hepatitis A,B or C | Y/N |
| Pacemaker | Y/N | Epilepsy | Y/N |
| Excessive Bleeding | Y/N | Jaundice | Y/N |
| Stroke | Y/N | Organ Transplant | Y/N |
| Rheumatic Fever | Y/N | Osteoporosis | Y/N |
| Anemia or Blood Disease | Y/N | Arthritis | Y/N |
| Blood Transfusion: Date……... | Y/N | Glaucoma | Y/N |
| Fainting Spells | Y/N | Neurosis/Nervous Disorders | Y/N |
| Shortness of Breath | Y/N | Dry Mouth | Y/N |
| Asthma | Y/N | Cancer | Y/N |
| Hayfever | Y/N | Deep X-ray Therapy | Y/N |
| Tuberculosis or other lung disease | Y/N | | |

BONE RELATED DRUGS-
Pamidronate (Acedia) Y/N Tiludronate Y/N
Zoledronate (Zomata) Y/N Etidronate Y/N
Risendronate (Actonel) Y/N Clonronate Y/N
(Fosamax) Y/N

**Do you have any allergies?.........................................................................**
Are you a smoker? Y/N How Many per day?......... For how many years?.........
Are you or could you be pregnant? Y/N
The information contained within will be treated with strict confidence.

Signed……………………………………………….Dated……………………………..

## Privacy Policy

Our Practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

The policy of your practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2. We may disclose your health information to other health care professionals, including specialists we may refer you to, or require it from them, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual service fees will apply.

5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in your treatment, without your written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Otherwise, please sign this form as a confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

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

Our staff follow standard precautions when handling sharps, however, due to the nature of dentistry penetrating injuries can occur, such an injury can be stressful to for the staff member. To reduce the anxiety associated with a sharps injury we ask that is such a case the patient agrees to a blood test.

In the case of a staff member receiving a penetrating sharps injury, I agree to a blood test if requested, the cost of which will be paid for by walshdental.

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