Dr. G. Pitcher
Dr. A. Moore
Dr. S. Nadebaum
Dr. M. Hayes

DENTAL SURGEONS

Jetty Road Dental Clinic
106 Jetty Road
Glenelg 5045
Telephone 82952607

WE RESPECT YOUR PRIVACY

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details but it is also necessary to obtain from you details regarding your general health. Without this general health picture, the treating dentist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as "sensitive" and not the sort of information that you would wish to be unnecessarily disclosed to others.

This practice is committed to safeguarding the personal information of patients and staff in line with its obligations under Commonwealth legislation as well as guidelines set by Industry regulatory bodies such as the Australian Dental Board.

A copy of our privacy policy is available on request.

PERSONAL RECORD SHEET

GIVEN NAMES: ..... SURNAME: .....

TITLE: Dr. / Mr / Mrs / Miss / Ms..... DATE OF BIRTH: .....

ADDRESS: ..... POSTCODE: .....

TELEPHONE: (Home)..... (Work) ..... (Mobile) .....

EMAIL:.....

OCCUPATION:..... EMPLOYER: .....

NEXT OF KIN: ..... CONTACT NUMBER: .....

NAME OF PERSON RESPONSIBLE FOR ACCOUNT:.....

ADDRESS (if different from above):.....

..... POSTCODE: .....

WHO SHOULD WE THANK FOR REFERRING YOU TO THIS PRACTICE? .....

NAME OF DENTAL BENEFIT FUND: .....

ARE YOU COVERED BY DEPARTMENT OF VETERANS' AFFAIRS (DVA) OR S.A. DENTAL SERVICE (SADS)? (underline if yes)

NAME OF MEDICAL PRACTITIONER: .....

SUBURB:.....

— Please complete information on the other side of this sheet —

MEDICAL AND DENTAL HISTORY

1. Are you taking any tablets or medicines? YES / NO

   If so, what?.....

   .....

   .....

   .....

2. Have you ever had any serious illness? YES / NO

   If so, what?.....

3. Do you suffer any allergies? YES / NO

   If so, what?.....

4. Do you or have you suffered (underline if yes)

   (a) heart trouble
   (b) high blood pressure
   (c) rheumatic fever
   (d) asthma
   (e) diabetes
   (f) hepatitis
   (g) epilepsy
   (h) abnormal bleeding
   (i) joint replacements eg. hip, knee etc.
   (j) HIV, A.I.D.S. or associated risk groups
   (k) Sleep Apnoea
   (l) Any other

5. Women — are you pregnant? YES / NO
   — approximate due date?

6. How long is it since your last visit to a dentist? .....

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

8. Do you normally have a local anaesthetic injection for dental treatment? YES / NO

9. Have you experienced (underline if yes)
   (a) unfavourable reaction to local anaesthetic
   (b) difficult extractions

10. Do you have (underline if yes)
    (a) bleeding gums
    (b) bad breath
    (c) loose teeth

11. Are you dissatisfied with your teeth or their appearance? YES / NO
    Would you like to discuss the possibility of treatment for this? YES / NO

12. Are you aware of
    (a) clenching or grinding of your teeth? YES / NO
    (b) awakening with an awareness of your teeth or jaws? YES / NO
    (c) any clicking of jaws? YES / NO
    (d) tension headaches? YES / NO

Please inform us of any changes in the above details.

I CONSENT TO THE COLLECTION AND USE OF THIS INFORMATION FOR THE PURPOSE OF MY DENTAL TREATMENT AND TO THE DISCLOSURE OF THIS INFORMATION AS APPROPRIATE WITHIN THE NATIONAL PRIVACY PRINCIPLES.

SIGNATURE:..... DATE: .....