Dr Susan Hinckfuss & Dr Nicola Kilpatrick - Specialist Paediatric Dentist

PATIENT INFORMATION AND HISTORY

Surname:_____ First Name:_____

Preferred Name:_____ Age:_____ Birthdate:_____/____/_____ Gender: M / F

Address:_____ Suburb:_____ Postcode:_____

Mother's name:_____ Mobile:_____ Home phone number:_____

Father's name:_____ Mobile:_____ Email: _____

Parents status: Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Defacto ☐

Person responsible for account:_____

Address:_____ Suburb:_____ Postcode:_____

Emergency contact (not living at patient's address): Phone:_____ Relationship: _____

Patient referred by:_____ General Dentist:_____

Medical and Dental History

Please tick any of these conditions that the patient has had or has:

- ☐ Asthma
- ☐ Epilepsy
- ☐ Heart disease/murmur
  Rheumatic fever
- ☐ Breathing difficulties
- ☐ Diabetes
- ☐ Bleeding disorder
- ☐ Behavioural disorder
- ☐ Kidney disease
  Operations/hospitalisations
- ☐ AIDS
- ☐ Hepatitis A B C
- ☐ Food/drug allergy
- ☐ Growth problems
- ☐ Birth defects

Other special needs/ conditions_____

Please give details of any of the above noted _____

What drugs or medications is the patient now taking:_____

Who brushes the patient's teeth? Self(patient) Combined parent/child Parent
When is brushing performed? Morning – before / after breakfast Before bedtime Everyday / Not everyday

What dental problems has the patient had?_____

What is the reason for seeking dental care today?_____

On previous visits to the dentist has your child been anxious? Yes / No
If yes please describe: _____

Please describe any past accidents involving the teeth:_____

Private Health Insurance: Yes / No
Do you have Hospital Cover: Yes / No
Do you have Dental Extra's: Yes / No
Health Fund Name & Schedule: _____

Member No. _____

Medicare No. _____

Reference No. #_____
Are you eligible for :
Medicare Child Dental Benefits Scheme: Yes / No

Parent's signature:_____ Date:_____