

Welcome to our practice. The following information is requested to enable us to give your child our best attention. All questions and consultations are treated with confidentiality.



Patient Details

NAME:					
Date of Birth:	/	/	Gender:	Male/Female	
Address:					
EMAIL:					
Phone:			Alternate:		
Parent/guardian name:					
Is this person responsible for fees?	Yes/No If no. details:				
Private Insurance:	HOSPITAL :	Yes/No	DENTAL :	Yes/No	FUND:
Medicare Number:			Patient Id:	Exp:	
Medical Practitioner:				PH:	
Who referred you to our practice:					

Patient Medical History

Please tick if your child has ever been diagnosed with any of the following?

Heart murmur/surgery		Asthma		Cancer	
Epilepsy		Diabetes		Sensory impairment	
Liver disease (hepatitis)		Kidney disease		Autism/Asperger's Syndrome	
Childhood arthritis		Gastrointestinal diseases		Learning or developmental delay	
Bleeding disorders		HIV/AIDS		Creutzfeldt-Jacob Disease	
Cleft /clefting condition		Low/very low birthweight		Malignant hyperthermia	
Is your child's immunization up to date?				Yes/No	
Has your child ever had a general anaesthetic or sedation?				Yes/No	

Has your child ever suffered from any other significant illness or been diagnosed with a congenital or developmental anomaly? (Please list)

Please list any medications or dietary supplements your child is currently taking (Please include puffers, creams or supplements)

Please list any allergies your child has (eg latex, food & medicines)?

Reason for seeking care

Routine examination		Referral from dentist		Past difficult experience	
Dental trauma		Dental pain/infection		Other	

The information provided in this document is true and correct to the best of my knowledge at the time of signing and I am also aware of Newcastle Paediatric Dental Service's Privacy Policy.

Signed: _____ Date: _____

Welcome to our practice. The following information is requested to enable us to give your child our best attention. All questions and consultations are treated with confidentiality.



In order to provide your child with the highest standard of specialist dental care, this practice is required to collect personal information from you. This information covers basic details such as your child's name, address and telephone number but it is also necessary to obtain details regarding their general health and past medical and surgical events. Without this general health picture the dentist is unable to plan your care properly.

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

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- *This information will only be used by the treating Practitioner in order to deliver your care to the highest standards*
- *It will not be disclosed to those not associated with your treatment, without your express consent*
- *You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your records at the time of your appointment or by special access or copying information*
- *There will be no charge for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request for copying information*
- *We will take all reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date*
- *We will take all reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure*
- *Our staff are trained to respect these principles at all times.*

If you have any questions regarding the information we collect from you and hold in your records at this practice, please do not hesitate to ask us. We are acting in your interest at all times.

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Pre-appointment Questionnaire

Child's name _____ Parent's name _____

Child's birthday / / Child's age Today's date / /

Please list any concerns about your child's teeth and mouth.

How old was your child when you notice their first tooth

Do you have any concerns about your child's speech?

Did your child breast feed?

Does your child still use a bottle?

Does your child have or had any current or past oral habits (eg pacifier/dummy sucking, finger/thumb sucking, grinding. If yes please give details.

Has your child suffered any trauma to their teeth and/or mouth? If yes please give details.

Do you use tank or town water ? _____

Have either parent (or older sibling) had any significant issues with their teeth

Notes

Tooth number: missing/extra teeth,	Yes/NO _____
Chalky/poorly formed teeth	Yes/NO _____
Cleft lip/palate,	Yes/NO _____
Braces/orthodontics,	Yes/NO _____
Jaw surgery	Yes/NO _____

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