



**BRIGHT STAR**  
**DENTAL CENTRE**  
 your answer to a healthy smile

p. 03 9555 7441  
 f. 03 9555 7415

402 South Road (corner of Redholme St)  
 Moorabbin VIC 3189

info@brightstardental.com.au

Opening hours: (extended hours)  
 Monday – Friday 8.00am – 6.00pm  
 Tuesday 8.00am – 7:30pm  
 Saturday 8.30am – 1:30pm

[www.brightstardental.com.au](http://www.brightstardental.com.au)

**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 such as your name, address and telephone number, but it is also necessary for us to obtain from you details regarding your general health and past medical or surgical treatments and procedures. Without this general health profile, the treating Dentist or Hygienist is unable to plan your care properly.

Naturally, some of this information is of a personal nature, some of it may be regarded as 'sensitive' and not the sort of information you would 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 Dentist or Hygienist in order to deliver your care to the highest standards
- It will not be disclosed to those not associated with your treatment without your expressed consent
- You may seek access to the information held about you and we provide this access without undue delay. This access might be by inspection of your dental records at the time of your appointment or by special access or copying of information at other times
- There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.
- We will take 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 dental records, please do not hesitate to ask us. We are acting in your interests at all times.

Prof      Dr      Fr      Mr      Mrs      Ms      Miss      Master

Full Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Mobile phone \_\_\_\_\_

Email \_\_\_\_\_

Date of birth \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Health insurance \_\_\_\_\_

Contact person in case of emergency \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Person responsible for dental investment \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

What has been your concern with previous dental visits? \_\_\_\_\_

What is your main dental concern today? \_\_\_\_\_

Are your teeth sensitive to:

- Heat
- Cold
- Sweet
- Biting pressure

Does food catch between your teeth? \_\_\_\_\_

Do your gums bleed when brushing or flossing? \_\_\_\_\_

Do you notice an unpleasant taste or odour in your mouth? \_\_\_\_\_

Have you had any complications during or following dental treatment? \_\_\_\_\_

Have you had prolonged bleeding after tooth removal or dental surgery? \_\_\_\_\_

Is there anything you would like to change about your teeth or their appearance? \_\_\_\_\_

Do you grind your teeth or clench your jaws? \_\_\_\_\_

Have your jaw muscles ever been sore? Yes or No

Please describe how you feel about dental treatment by putting an X on this line

Pleasant \_\_\_\_\_ 0 \_\_\_\_\_ Terrible

Are you being treated for a medical condition? \_\_\_\_\_

Who is your doctor? \_\_\_\_\_

Are you taking any medications or supplements at present, both prescribed or over the counter?  
(Please list) \_\_\_\_\_

Are you taking any bisphosphonate medication or any other medication to treat osteoporosis?  
\_\_\_\_\_

Do you have, or have you ever had, any of the following medical conditions?

- |  |   |  |
|--|---|--|
| <input type="radio"/> Steroid therapy                  | <input type="radio"/> Stomach or digestive condition<br>e.g. reflux | <input type="radio"/> Excess bleeding                                  |
| <input type="radio"/> Rheumatic fever                  | <input type="radio"/> Leukaemia, cancer                             | <input type="radio"/> Hepatitis or liver disease                       |
| <input type="radio"/> Epilepsy                         | <input type="radio"/> Nervous condition                             | <input type="radio"/> Contact with HIV/AIDS virus                      |
| <input type="radio"/> Asthma                           | <input type="radio"/> Tuberculosis                                  | <input type="radio"/> Anaemia or blood disorder                        |
| <input type="radio"/> Diabetes                         | <input type="radio"/> Thyroid disease                               | <input type="radio"/> Prosthetic implant<br>eg. prosthetic hip or knee |
| <input type="radio"/> Heart valve disorder             | <input type="radio"/> Heart murmur                                  | <input type="radio"/> Bronchitis, emphysema or<br>other lung disease   |
| <input type="radio"/> Stroke                           | <input type="radio"/> High or low blood pressure                    | <input type="radio"/> Other _____                                      |
| <input type="radio"/> Radiation or chemotherapy        | <input type="radio"/> Transported organ or bone<br>marrow           | _____  |
| <input type="radio"/> Kidney disease                   | <input type="radio"/> Cardiac pacemaker                             | _____  |
| <input type="radio"/> Heart complaint or heart surgery |   |  |
| <input type="radio"/> Eating disorder                  |   |  |



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Please list all known allergies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke? \_\_\_\_\_

For females, are you pregnant or undergoing fertility treatment? \_\_\_\_\_

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_