Plympton Paediatric Dentists

Dr Michael Malandris
BDS, MDSc, FRACDS FICD
Dr Mary Apps
BDS, BScDent(Hons), DClinDent(Paed), MRACDS

293 Anzac Highway, Plympton SA 5038
P: 8293 8567
E: reception@plymptonpd.com.au

Personal Details and History Form

Child's details	
Surname:	
First name:	Preferred name:
Address:	
Date of birth: / /	Gender: □ female □ male
Child lives with: □ both parents; □ mother; □ father; □ other – please specify: Has another member of your family attended our clinic before? Yes/No If yes, please let us know their name:	
Private Health Insurance Company:	Type of cover: (e.g. hospital, extras only)
Member No:	Line No:
Medicare Card No:	Line No:
Parent/Guardian details (the person who will be liaising with us the most)	
Surname:	First Name:
Title: Mr Mrs Ms Miss Dr Other:	Relationship to child:
Address:	
First Phone Contact: (Please specify Hm/Mob/Wk)	Other: (Hm/Mob/Wk)
e-mail:	Occupation:
Other Parent/Guardian details (if there is no second parent/guardian involved in the care of this child, please give details of another family member or friend that could be contacted in case of an emergency)	
Surname:	First Name:
Title: Mr Mrs Ms Miss Dr Other:	Relationship to child:
Address:	
Phone (Please specify Hm/Mob/Wk):	
e-mail:	Occupation:

Child's dental history
Please provide details of any dental treatment your child has had before:
Has your child suffered from any injuries in the past that affected the mouth or teeth? □ no □ yes
Please tick box if your child has or ever had any of the following habits: □ thumb/finger sucking □ dummy/pacifier □ other □ no
Chief dental complaint:

Pregnancy, birth and postnatal history
Gestational age: □ full term □premature Birth weight:
Were there birth complications/medical problems from 0 – 3 years of age? Medical specialists seen:

Child's medical history
Details of general medical practitioner (or clinic):
Please provide details of any illnesses or conditions that are relevant to your child:
Please list any previous hospitalisations and/or operations: Please provide details of complications from any previous hospital admission or general anaesthetic procedure:
Please list any medications or supplements that are taken regularly by your child:
Does your child have any allergies or hypersensitivity reactions? (e.g. latex, penicillin, foods) Yes □ No □ If yes, please give details:
Has your child or any other family member had an adverse reaction to a local or general anaesthetic? Yes □ No □ If yes, please give details:
Is your child up-to-date with their immunisations? Yes □ No □

Financial/Medical Consent
Are there any parenting orders in place that we need to know about prior to obtaining any financial or medical consent? Yes/No

If yes, please provide details:

I accept personal responsibility for full payment of the practice account, or balance remaining, in the event that my health insurance claim is rejected in full or partly paid, as applicable. I understand that total costs cannot be quoted, but only estimated in advance.

I also confirm that I have authority to consent to treatment for this child and that no other parent/guardian consultation is required for this consent to be valid.

_____	_____	___/___/___
Name	Signature	Date