

PERSONAL DETAILS:

Full Name - Mr/Mrs/Miss/Ms: _____

Preferred Name: _____

Date of Birth: ____ / ____ / ____ Sex: M / F Occupation: _____

Home Street Address: _____

Post Code: _____

Email Address: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

Who is responsible for your account? : _____

*Do you have private dental health insurance? Yes / No

*Name of Fund: _____

Medicare No: _____ Reference Number (No. Beside Name): ____

How did you find out about our practice? (Please Tick)

Walked Past Internet "Word of mouth" Other

DENTAL HISTORY:

Name of previous dentist & location? _____

Last dental visit: _____ Reason: _____

What is the main reason for today's visit? _____

Have you ever experienced any problems with previous dental treatment, procedures or anesthetic? Yes / No?

Does dental treatment make you nervous? (Please Circle)

No Slightly Moderate Extremely

Please Turn Over _____→

MEDICAL HISTORY

o Name & Location of GP _____

o Names/s of any Specialists and Location _____

Emergency contact name: _____ **Number:** _____

Heart		Chest	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Smoker / Past Smoker
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Pacemaker fitted		<input type="checkbox"/> Chest Surgery	

Details _____

Details _____

Blood		Other	
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Abnormal Blood Test	<input type="checkbox"/> Serious Childhood Illness	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> H.I.V.	<input type="checkbox"/> Haemophilia	<input type="checkbox"/> Liver Disease <small>Type I or II</small>	<input type="checkbox"/> G.A. Experience
<input type="checkbox"/> Anaemia		<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hiatus Hernia

Details _____

Details _____

Allergies		Warnings	
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> No Local Anaesthetic	<input type="checkbox"/> Warning Card
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Asthmatic	<input type="checkbox"/> Anti Biotic Cover	<input type="checkbox"/> Artificial Joint
<input type="checkbox"/> Anti Tetanus Serum	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Do Not Recline	<input checked="" type="checkbox"/> Dental Phobia
<input type="checkbox"/> Eczema	<input checked="" type="checkbox"/> Codine	<input type="checkbox"/> Pregnant	<input checked="" type="checkbox"/> Arthritis or Osteoporsis

Details _____

Details _____

Medication	

CONSENT FOR SERVICES:

- I hereby declare the information provided to be correct & true.
- I consent to the performing of dental procedures agreed to be necessary or advisable and accept responsibility for the fees associated with those procedures and that payment is required on the day.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment. A cancellation fee of \$50.00 may be incurred if I fail to do so.

PRIVACY POLICY:

I have read and understand the Surgery's Privacy Policy and agree to this policy as well as receiving SMS messages with appointment reminders if applicable.

Name: _____ Date: _____

Signature: _____