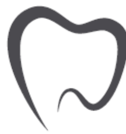

DENTIST
& Co.

(02) 9810 3044

In the interest of your treatment, all questions must be answered to the best of your knowledge.
All information is kept strictly confidential.

Title Mr, Mrs, Ms, Miss, Other ……	**Date of Birth** (DD/MM/YYYY)
Surname	**Given Name(s)**

Mobile # **Home#** **Work #**

Address	**Suburb** **Postcode**
Email	**Occupation**

Emergency contact:
Name: ______________________________
Relationship: _________________________
Phone #: _____________________________

Private Health Fund: _____________________
Card Number: ____________________________
Patient Series number (beside the name): ______

How did you hear about us? *Please tick*

O Google Search **O** Facebook **O** Instagram **O** Dentist & Co. Marketing

O Other ……………………….. **O** Friends/Family member ..…………………………………….

Please nominate your referring friend/family member so that we may thank them for their kind referral

<u>Medical History</u> Do you currently have or have a history of the following *Please tick*

O Heart Disease	O Blood Disease	O Epilepsy	O Asthma
O Lung Disease	O Heart Murmur	O Diabetes	O Smoking
O Prosthetic Heart Valves	O Kidney Disease	O Hepatitis A, B or C	O Stroke
O Aids/HIV	O Radiation Therapy	O Liver Disease	O Cancer
O Pacemaker	O Rheumatic Fever	O Chemotherapy	O Measles
O Bone Disease	O Tuberculosis	O Artificial Joints	
O Excessive Bleeding	O Taking Bisphosphonates		

Do you snore or have sleep apnoea?	Yes / No
Does your partner snore or have sleep apnoea?	Yes / No
Have you had or plan to have Botox Treatment?	Yes / No
Have you had or plan to have Dermal Fillers?	Yes / No

Any other illnesses? Yes / No *Please specify……………………………….*

Do you have any allergies? Yes / No *Please specify……………………………….*

Are you taking any medications? Yes / No *Please specify………………………………..*

Have you had any adverse reaction to any drug? Yes / No *Please specify………………………..*

Have you been in hospital recently? Yes / No *Please explain ……………………………….*

Are you, or could you be, pregnant? Yes / No *Due date?.....................................*

Name and Contact of your usual Medical Practitioner………………………………………….

Dental History

What would you like to achieve from your visit today? ……………………………………………………

When was the last time you visited the dentist? Years ____ Months ______

Are you experiencing or concerned about any of the following dental problems? *Please tick*

O sensitivity to hot or cold O food trapping between teeth O grinding your teeth

O staining of your teeth O discoloured fillings O chipped/rough fillings

O bleeding gums O bad breath O pain when chewing/eating

O head/neck ache O clicking or pain in jaw joints

Are you concerned about any of the following? *Please tick*

O existing crowns, bridges or dentures? O ability to eat O silver fillings (amalgam)

O missing teeth O crooked teeth O gaps between your teeth

O previous dental treatment

Would you like to discuss teeth straightening with us? Yes / No

Are you interested in discussing teeth whitening with us? Yes / No

What kind of toothbrush and toothpaste do you use?……………………………………………

IMPORTANT INFORMATION- PLEASE READ

I understand that payment is due at the time of services, unless other arrangements have been made with the treating practitioner **prior** to commencing treatment. I understand and accept that additional fees and charges are incurred in collecting unpaid accounts. We have the **Hicaps** facility where we can claim for your benefits directly from your health fund. We also accept **Credit card** and **Cash.** We also offer **Interest Free Payment plans**, feel free to discuss this option with us. Unfortunately, we do not accept personal cheques.

The practice requires at least 24 hours notice of any cancellations; failure to do so will incur a cancellation fee of $50 per every 30mins

We will endeavour to remind you the day before via sms of your appointment. However, the responsibility is for you to remember your appointment details. Please discuss with us if you wish NOT to be reminded via sms.

Any x-rays or pictures taken of you or your teeth may be used for teaching or marketing purposes. Your identity will remain confidential unless otherwise discussed with you by the Dentist. If you have any concerns, feel free to bring it up with us.

***Signature* X__________________** **Date __ __/__ __/__ __ __ __**

Office Use Only CP ☐ Scanned ☐ Initial ☐