

Preferred title: _____ Date of Birth ____/____/____

First Name _____

Last Name _____

Preferred Name _____

Address _____

Suburb _____ Postcode _____

Contact Phone Number _____

Email _____@_____

Parent / Guardian name
(if applicable) _____

Carer name _____
(if applicable)

Contact Phone Number _____

Emergency Contact Name _____

Contact Phone Number _____

Person responsible for the fees? Self Other
Name _____

Address _____

Phone number: _____

Do you have Private Health Insurance? Yes No
 Hospital Dental
Fund _____ Ref. Number _____

Policy Number _____

Are you eligible for the Child Dental Benefits Schedule (CDBS)? Yes No

Medicare Card Number: _____ Ref # _____

Department of Veterans Affairs' Card Number
(if applicable) _____

Is this consultation related to Workcover or a Work related injury or Transport Accident? Yes No

Please take care to fill out this form completely. We rely on all your information to be able to provide you with appropriate dental services.

Privacy Policy – We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Would you like to receive an appointment reminder?

Yes No
 Email SMS Phone Mail

Would you like to receive newsletters and notification of special offers? Yes No

Email SMS Phone Mail

Medical History

To the best of your knowledge do you have or have you suffered from the following? If possible please provide approximate date of diagnosis.

- Stroke _____
- High Blood Pressure _____
- Arthritis _____
- Heart Disease _____
- Anxiety _____
- Digestive problems _____
- Asthma _____
- Osteoporosis _____
- Respiratory _____
- Lung disease _____
- Diabetes _____
- Infectious Diseases _____
- HIV / Aids _____
- Pacemaker _____
- Back or neck problems _____
- Cancer If so, where _____
- Neurological(nerves) problems _____
- Other _____

Are you pregnant? If so, how many weeks? _____

Please state any major surgery you have had in the last five years _____

Do you/have you received treatment for jaw related problems? _____

Do you smoke? Yes No
If Yes how many per day? _____

Do you drink alcohol regularly? Yes No

Any other relevant medical history? _____

Allergies and Adverse Reactions

Do you have any allergies? Yes No

Do you have any adverse reactions to drugs? Yes No

If Yes please state allergy/reaction _____
Emergency Plan _____

Medicines

There are many medications that may impact upon your oral health or the treatment we plan for you. Please indicate any medications that you are currently taking or have taken recently (including natural therapies).

Alternatively a list from your GP can be attached.

- _____
- _____
- _____
- _____

Are you on any blood thinners such as Warfarin or Aspirin? Yes No

Is there anything else you would like to discuss in private? Yes No

I agree to be responsible for all payment of fees and understand that payment is due at the time of the service.

Patient/Guardian Signature _____ (if applicable)

Signature _____ Date ____/____/____