**Mr/Mrs/Miss/Ms/Dr/Master**

|  |  |  |
| --- | --- | --- |
| **Surname:** |  | **Given Names:** |
| **Date of Birth:** |  | **Occupation:** |
| **Phone (H)** |  | **Home Address:** |  |
| **Phone (W)** |  |
| **Phone (Mobile)** |  |
| **REMINDER PREFERENCE** ***(Please circle)*** | **SMS** | **Letter**  | **Telephone call** |

**EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Health Fund(name)** | **Patient ref number:**  **01 / 02 / 03 / 04)** | **Member card number:** |
| **Medicare Number**  | **Patient ref. Number on card:****1 / 2 / 3 / 4 / 5** |  |

**How did you find out about us?**

|  |
| --- |
| **○ Internet ○ Walked past ○ Local Paper ○ Word of Mouth ○ Medical Practice** o **Flyer****○ Patient ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (please provide name so we can thank them) |

**Medical History GP / DOCTOR DETAILS:**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please tick if you have ever had the following:**

|  |  |  |
| --- | --- | --- |
| **○ Anaemia** | **○ Fainting** | **○ Pacemaker** |
| **○ Artificial Joints** | **○ Glaucoma** | **○ Radiation Therapy** |
| **○ Asthma** | **○ Heart Disease** | **○ Respiratory Problems** |
| **○ Blood Disease** | **○ Heart Murmur** | **○ Rheumatic Fever** |
| **○ Cancer** | **○ Hep A,B or C** | **○ Sinus Problems** |
| **○ Dizziness** | **○ Jaundice** | **○ Stroke** |
| **○ Epilepsy** | **○ Kidney Disease** | **○ Tuberculosis** |
| **○ Excessive Bleeding** | **○ Liver Disease** | **○ Tumours** |
| **○ Diabetes** | **○ HIV/AIDS** | **○ Psychological Disorders** |

**Are you taking any medications? ○ Y ○ N** (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies?** (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DENTAL HISTORY**

**Do you experience any of the following?**

|  |  |  |
| --- | --- | --- |
| **○ Sensitivity hot/cold** | **○ Food traps** | **○ Clicking/Pain in jaw** |
| **○ Grind/Clench** | **○ Bleeding gums** | **○ Bad breath** |

**Are you concerned about or experiencing any of the following?**

**(Please tick as many as applies)**

|  |  |  |
| --- | --- | --- |
| **○Sleep Apnoea** | **○Gaps between teeth** | **○Teeth cleaning methods** |
| **○Existing crown/bridge** | **○Your smile** | **○Discolouration of teeth** |
| **○Crooked teeth** | **○Silver fillings** | **○Missing teeth** |
| **○Abscess** | **○Previous dental treatment** | **○Existing denture** |

**What is the Purpose of your visit today?**

**­­­­How long since your last dental visit?**

**Have you had dental x-rays in the last 12months? Yes ○ No ○**

Consent for treatment: I hereby authorise the dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist and mutually agreed to make thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed on by me. I agree to the use of anaesthetics, sedatives, and other medication as necessary. I understand that using anaesthetics agents embodies certain risks. I agree to be responsible for payment of all services rendered on my behalf and behalf of my dependants. I understand that payment is due at time of service. A debt collection fee will be applicable if this service is used. If you are unable to make your appointment and fail to notify us 24 HOURS before appointment there will be a cancellation fee of $100. I authorise that this data may be reviewed by team members of the dental practice.

**Patient Signature / Guardian Signature: Date signed:**