toowong village dental
general, cosmetic & implant dentistry

CONFIDENTIAL INFORMATION

DO YOU HAVE ANY FLU LIKE SYMPTOMS? Yes/No
IF YES, NOTIFY OUR RECEPTIONIST IMMEDIATELY

Dr / Mr / Mrs / Ms / Miss / Master / Mx (please circle)
Surname: _____ First Name: _____
Date of Birth: _____
Home Address: _____
_____
Postal Address: _____
Home Ph: _____ Work Ph: _____
Mobile:_____ Email:_____
Occupation/Employer: _____
Emergency Contact Name: _____ Ph: _____
Private Health Fund: Yes/No; if Yes, which fund? _____
If yes, does your Private Health Insurance include "Dental"? Yes/No

Are you a member of Smile.com.au? Yes/No
If yes, what is your Smile member number and expiry? _____

CONFIDENTIAL MEDICAL HISTORY

Do you currently have, or have you ever been treated for any of the following conditions?

	YES	NO		YES	NO
Recently taken steroids			Joint replacement surgery		
Taking any anticoagulants or bisphosphonates			Bad reaction to local or general anesthetic		
Allergic to latex materials			Arthritis		
HIV (confirmed or suspected contact)			Prolonged bleeding after trauma or surgery		
Hepatitis A B C (please circle)			Diabetes		
Rheumatic Fever			Epilepsy		
Heart Murmur			Pacemaker		
Heart Attack or other heart problems			Asthma		
Kidney Disease			Bronchitis or another Lung Disease		

How did you find out about our Practice? _____

Do you regularly attend another Dentist? Yes/No

If yes, who? _____

Are you receiving treatment from a doctor or specialist? Yes/No

If yes, please advise: _____

Are you taking any drugs or medications? Yes/No

If yes, please advise: _____

Do you have any known allergies (drugs, food, materials)? Yes/No

If yes, please list:_____

Do you smoke? Yes/No

If yes, please advise how many per day and for how many years: _____

_____

For female patients, are you pregnant? Yes/No

Are there any other aspects of your health that you feel the dentist should know about?

_____

_____

PERMISSIONS

Do you give permission for the dentist to take photos of your teeth? Yes/No

Do you give permission for the photos taken to be used in professional presentations? Yes/No

Who is responsible for your fees? _____

How will you usually pay for treatment? Cash / Cheque / Visa or Mastercard / Eftpos (please circle)

I acknowledge that fees incurred are due and payable on the day of treatment unless prior arrangement has been made. I understand and accept that collection fees and costs will be applied as required to recover overdue accounts.

I understand that 24 hours' notice is required to reschedule an appointment.

Signature: _____ ***Date:*** _____