Welcome! Thank you for choosing our practice.

We'd like to know a little bit more about you.

Full name (Mr/Mrs/Ms/Miss/Mst)_____
Date of birth____/_____/_____Address_____Postcode__ __ __ __
Phone (home) _____ (work) _____ (mobile) _____
Email _____Occupation_____
Emergency contact _____Phone_____
Name of Private Health Fund _____2 Digit Reference Number ___ ___
Medicare number or drivers licence number_____
Preferred contact method for follow up appointments (please circle) SMS or Phone call (Home / Work /Mob) or Email

Medical History

Who is your GP? _____phone:_____
Please circle the appropriate alternative, if you answer yes, please provide details in the relevant section below#.
Have you had any serious health issues in the past year?_____ YES/ NO
Have you ever experienced adverse reaction to any treatment/medication?____ YES/ NO
Are you pregnant? YES/NO If Yes, how many months?
#Details_____
_____

Please circle the appropriate alternative,

Abnormal Bleeding	YES / NO	Hepatitis A B C	YES / NO
Artificial Heart Valve	YES / NO	HIV positive	YES / NO
Blood pressure High/Low	YES / NO	Pregnant Due date_____	YES / NO
Bisphosphonates i.e. Fosamax	YES / NO	Radiation or Chemotherapy	YES / NO
Cardiac surgery/Pacemaker	YES / NO	Rheumatic Heart Disease	YES / NO
Diabetes Type1/Type 2	YES / NO	Warfarin Medication	YES / NO
Snore or sleep restlessly?	YES / NO	Are you taking any medications?	YES / NO
Eating disorder	YES / NO	Please list _____	
Epilepsy	YES / NO	_____	
Joint replacement	YES / NO	Other health issues:_____	
Heart Conditions	YES / NO	_____	
Smoker number per day_____	YES / NO		

Allergies

Penicillin YES / NO Aspirin YES / NO Iodine YES / NO Sulpha Drugs YES / NO Latex YES / NO
Other (specify allergies _____
When was your last dental visit?_____
How did you hear about us? Website /Google
Friend/family /colleague (whom may we thank?) _____**Other**_____

Please Note-: Settlement of your account is due on the day of treatment. Please see Reception after your appointment to arrange payment.
We are happy to reschedule your appointment when necessary, please advise us 24 hours priorly of any reschedule or cancellation requirements. A fee of $75.00 will be incurred for unattended appointments.
I have accurately completed the medical history form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me to be carried out by the dentists and their staff.
I authorize my dentist to take images of my teeth before and after treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients. My identity will remain anonymous.

Signature-:_____**Date**: ___/____/___