Pimpama Dental

Patient Information Form

Title: _____ First Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: _____ Gender: M / F

Address: _____

Suburb: _____ State: _____ Post Code: _____ Mobile: _____

Home Ph: _____ Work Ph: _____ Email:_____

Do you belong to a health fund? Y / N Fund Name: _____

Emergency contact person: Name _____ Ph: _____

What are your concerns today, regarding your teeth or mouth? _____

On a scale of 1-10, how would you describe your level of anxiety about your visit today?

Least anxious ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Most Anxious

If you could change anything about your smile, what would it be? _____

How did you hear of our practice?

☐ Yellow Pages ☐ Health Fund ☐ Mail Drop ☐ Medical Centre ☐ Radio ☐ Walk-by

☐ Internet ☐ Facebook ☐ Sea Sweet Newsletter ☐ The Local Newsletter ☐ Other .....

☐ Patient Referral If so, name of person who referred you (if applicable) .....

PAYMENT WILL BE REQUIRED ON THE DAY OF TREATMENT

All emergency dental services, or any dental services performed, must be paid for at the time services are performed. We accept cash, EFTPOS, HICAPS and all major credit cards. Fees may also be applied for missed appointments or appointments cancelled without two working days' notice.

PLEASE TURN OVER THE PAGE

Medical History: G.P Name: _____

Do you normally require antibiotic cover before Dental treatment? Y / N
Have you had any abnormal reactions to local or general anaesthesia? Y / N
Do you Smoke? Y / N
Are you being treated by a doctor at present? Y / N
Allergies – Please Specify, e.g. penicillin, latex, foods and preservatives _____
Have you been hospitalized within the last 12 months? Y / N
Women, if pregnant, what is your expected date due? _____
Are you taking any prescription or other medications at present? Y / N Please list: _____

_____

HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Please tick either YES or NO as appropriate.

	YES	NO		YES	NO		YES	NO
Steroid Therapy			Kidney Disease			Prosthetic Implant eg artificial hip		
Rheumatic Fever			Excessive Bleeding			Osteoporosis (bisphosphonate therapy)		
Drug Dependence			Arthritis			Organ transplant		
Epilepsy			Stroke			Stomach or digestive condition		
Asthma			Cancer			Hepatitis (A, B or C) or liver diseases		
Diabetes			Radiation/Chemo Therapy			HIV or AIDS		
Heart disorder			Thyroid Disease			Bronchitis, emphysema or other lung diseases		
Cardiac Pacemaker			Nervous condition			Anaemia, leukaemia or other blood diseases		
Tuberculosis			High or low blood pressure H / L			Do you, or have you had Botox or Dermal fillers?		
Autism/Aspergers ADHD (pls circle)			Other Behaviour Disorders			Psychiatric condition		

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist in private about this *(please tick box).* ☐

For all patients

I hereby authorise the dentist to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorise and consent to the dentist choosing and employing such assistance as he/she deems fit. I also understand that prior to treatment a full explanation of the procedure(s) involved will be given by the dentist and/or staff. I agree to pay for all services rendered, by this office. I also consent to the use of periodic appointment reminder phone calls, SMS or email as indicated on this form. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change to my health, I will inform the dentist at my next appointment without fail.

I have read the above conditions of treatment and agree to their content.

Signature: _____ Date: _____
(Patient / parent / guardian)