WELCOME TO KAWANA DENTAL

PLEASE READ AND ANSWER ALL QUESTIONS

YOUR PRIVACY IS IMPORTANT AND YOUR INFORMATION WILL BE KEPT CONFIDENTIAL

Title: Dr, Mr, Mrs, Ms, Miss, Master **Surname:**……

First Name:……. **Middle Name:**……

Preferred Name (Nickname): …… **Date of Birth**:……

Email:……(Don't worry, we hate spam too!!)

Mobile: ……**Phone No:** …… **Work No**: ……..

Address: ……

…….. **Post Code**: ……..

Occupation: ……

In case of Emergency Contact Name & Phone number

Name ……

Relation……

Contact number ……

HOW DID YOU HEAR ABOUT US?

Name of person/patient……

OR FOUND US THROUGH (Please circle below)

Google Internet Search Tooth Sign Yellow Pages Book/Online Facebook Other (please specify) ……

DENTAL HISTORY

When was your last dental visit? ……

Do you have any problems or fear related to dental treatment? Yes / No

(Please list) ……

Do you have any concerns about your mouth/teeth? Yes / No

(Please list) ……

Are you interested in improving the appearance or colour of your teeth? Yes / No

Have you ever had a hygienist clean & polish your teeth? Yes / No

Have you had a look at the information on our Website? Yes / No

ACCOUNT DETAILS

We require payment in full on the day of treatment, we do not issue accounts. If you have any concerns with this please discuss with reception.

Name of person responsible for PAYING the account (Eg. SELF) ……

Relationship to patient …… Ph: ……

Address……

Signature of responsible party (required)……

Are you in a Health Fund? (Please circle) Yes/No

Health Fund: ……Member No: …… Patient No (e.g 01 or 02) ……

MEDICARE NUMBER: _ _ _ _ _ _ _ _ _ _ ***(Family) #*** __ ***(Before Your Name)***

Exp:- _ _ / _ _ _ _

MEDICAL HISTORY

I have confidential information I wish to discuss with the dentist? **Yes/No**

Please tick/ circle if any of the below apply to you

Rheumatic Fever	Snore (or have sleep apnoea)
Asthma	Bronchitis, emphysema or other lung diseases
Diabetes Type 1 or 2	H.I.V positive test or A.I.D.S
Smoker	Radiotherapy/ Chemo/ Cancer Therapy
High Blood Pressure	Artificial Joint/ heart valve or pacemaker
Low Blood Pressure	Are you Pregnant?
Heart Problems/Murmur	Hepatitis A B C or other liver disease
Rheumatoid arthritis	Stomach or digestive condition including reflux
Recreational drugs	Blood thinners/bleeding problems
Epilepsy	Anything to help strengthen your bones
Anaemia, leukaemia, or other blood diseases	Other? please list _____

Have you had any abnormal reaction to local/ general anaesthetics/ twilight? **Yes/No**

If yes please explain……

Are you at present receiving medical treatment? **Yes/No (If Yes, name of) Dr** ……..

Please list any medications below you may be taking (INCLUDING herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants, inhalers, creams, ointments, patches, eye drops, nasal sprays) so we can take appropriate precautions and avoid drug interactions.

Drug Name	Dose taken (e.g. 50mg twice a day)	Duration of use (e.g. 5 months, 2 years)	Purpose (optional)

Please list any know allergies or adverse reactions to drugs or other agents (especially antibiotics e.g. penicillin), medicines, antiseptics, local anaesthetics, preservatives, or other agents (e.g. latex) that we should know about.

Name	Nature of Reaction	How long ago

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable and I will assume responsibility for the fees associated with those procedures.
- I understand diagnostic tools such as x-rays, photographs and study models may be required prior to the commencement of certain dental procedures.
- I understand that the practice requires at least 24 hours notice if I need to cancel or change my scheduled appointment and that a cancellation fee of $100.00 may be charged if I fail to do so.
- I am aware that full payment is required on the day of treatment.
- I acknowledge that the information given on this form is true and accurate to the best of my knowledge. It is my responsibility to inform the dentist of any changes in my medical status.

Patient/Guardian Signature: _____ Date: ____/____/____

CONSENT FOR EXCHANGE OF INFORMATION

I consent to health professionals who have treated me exchanging information about me as required via phone, mail or email to assist in providing oral health care to me.

Patient/Guardian Signature: _____ Date: ____/____/____

Our aim is to see our patients on time. We realise that you often have other time obligations. However due to the nature of our services we occasionally run behind. If we are running late, it may well be the result of an emergency and we appreciate your patience in this situation.

SHOULD YOU WISH TO UTILISE THE MEDICARE CHILD DENTAL BENEFIT SCHEME FOR YOUR CHILD TODAY PLEASE ENSURE YOU HAVE ADVISED RECEPTION PRIOR TO THE APPOINTMENT.