UPDATED MEDICAL- 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:…… **Date of Birth**:……

Have any of your contact details changed? Please circle **Yes/No** **(If yes please advise below)**

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

Mobile:……**Phone No**:……

Address:……

……**Post Code**: ……

Occupation: ……

In case of Emergency Contact Name & Phone number

Name …….

Relation…….

Contact number …….

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

ACCOUNT DETAILS

Are you in a dental health fund? **Yes/ No**

If yes which Health Fund?……...……Member No: ……. Patient No e.g (01 or 02) ……

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

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.
- 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: ____/____/____