Welcome to Kawana Dental

Your privacy is important, and all information will be kept strictly confidential

Title: **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 who referred you:

OR found us through *(please tick all that apply):*

☐ Google / Internet Search ☐ Building Signage ☐ Facebook / Instagram

☐ Other, please specify:

DENTAL HISTORY

When was your last dental visit?

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

If yes, please list:

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

If yes, 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

Are you in a Health Fund? Yes ☐ No ☐

Health Fund: Member No: Patient No:

MEDICARE NUMBER: *(Family) #:* *Exp (MM/YYYY):*

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 (if not self):

Relationship to patient: Ph:

Address:

Signature of responsible party (required, type full name):

MEDICAL HISTORY

I have confidential information I wish to discuss with the dentist: Yes ☐ No ☐

Please tick if any of the below apply to you:

- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Diabetes Type 1 or 2
- ☐ Smoker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Problems / Murmur
- ☐ Rheumatoid Arthritis
- ☐ Recreational Drugs
- ☐ Epilepsy
- ☐ Anaemia, Leukaemia, or Other Blood Diseases
- ☐ Snore (or have sleep apnoea)
- ☐ Bronchitis, Emphysema or Other Lung Disease
- ☐ H.I.V Positive Test or A.I.D.S
- ☐ Radiotherapy / Chemo / Cancer Therapy
- ☐ Artificial Joint / Heart Valve or Pacemaker
- ☐ Are You Pregnant?
- ☐ Hepatitis ☐ A ☐ B ☐ C or other liver disease
- ☐ Stomach or Digestive Condition, incl. Reflux
- ☐ Blood Thinners / Bleeding Problems
- ☐ Anything to Help Strengthen Your Bones
- ☐ Other, please list:

Abnormal reaction to local / general anaesthetics / twilight sedation? Yes ☐ No ☐

If yes, please explain:

Are you at present receiving medical treatment? Yes ☐ No ☐ If yes, Dr's name:

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.
If you have a printed list, please attach it or give it to reception.

Drug Name	Dose (e.g. 50mg, 2x/day)	Duration (e.g. 5 months)	Purpose (optional)

Please list any known 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).

Name	Nature of Reaction	How Long Ago

Consent Form

• 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.

• Some dental procedures at Kawana Dental will require a booking deposit to secure your treatment. If a booking deposit is required, our hours of notice to reschedule / change of mind may also change. The booking deposit varies according to the treatment required and will be discussed with you at the time of booking your appointment.

Patient / Guardian Signature (type full name): _____ 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.

***** OFFICE USE ONLY *****

MED HX* ☐ _____ **REF'D BY** ☐ _____

R/C SETUP ☐ _____ **ENTERED REC** ☐ _____