Personal Details

Title: ☐ Mr ☐ Master ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

Patient Name: ______________________________________ Birth Date: _________________ ☐ Male ☐ Female

Phone(Home): _____________________ (Work): _____________________ (Mobile): ___________________

Postal Address: ____

Email Address: ____

Preferred means of contact: ☐ SMS ☐ Phone call ☐ Email ☐ Letter ☐ Other _________________________

Who may we thank for referring you to our practice? ☐ Another patient (friend or relative) ____________________

☐ Hospital Office ☐ Yellow Pages ☐ Newspaper ☐ Online ☐ Radio ☐ Other ___________________________

Do you have private health insurance: ☐ Yes ☐ No If yes which fund: ________________________________

Do you have a family member who attends this practice? ☐ Yes ☐ No Name of family member: _______________

Would you like to be attached to their family file? ☐ Yes ☐ No

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Preferred appointments: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat am/pm

☐ Any

Are you the person responsible for paying the account? If not please provide the details below:

Name of person responsible for paying account: ________________________ Relationship to yourself: ________________

Phone: ___________________ Address: ____

Payment and Consent For Services

As a condition of your treatment, payment is due at the time of the appointment unless prior financial arrangements have been made. All emergency dental services, or any dental services performed without previous financial arrangements must be paid in full on the day of the appointment either by cash, cheque or credit card.

Patients with private health insurance can make their claim with the HICAPS machine on the day of service. The amount paid by the health fund is then paid directly to the dentist and the gap amount is then payable by the patient. Patients who are being treated under a Hospital Voucher, Medicare Scheme, DVA or other organization understand it is their responsibility to arrange and provide all required details and paperwork prior to appointment.

I understand I will be explained treatment options and given the opportunity to ask questions before treatment begins. I am aware that a variety of clinical records such as x-rays, photographs and comprehensive examinations may be required for the dentist to give an accurate and well-informed professional opinion and the refusal to have such records taken may limit the treatment services available to me.

I understand the practice requires 24hrs notice for cancellations and if I fail to provide sufficient notice a $50.00 fee may apply. I understand that if I fail to make prior financial arrangements and cannot pay for my appointment in full on the day of treatment that I run the risk of being sent to an outside agency for debt collection which will incur additional fees at the rate of 15%.

I grant my permission to be contacted if need be, to discuss matters related to this form, my appointments or my treatment. I have read, understood and will consent to the above conditions of treatment, including payment of treatment.

☐ I authorise the release of my patient records to Alice St Dental for their use in consultation with other dental professionals, education and research purposes and when required to seek opinions from a specialist

Signed: ___________________________ Date: ___________________

Health Information

- Date and reason for last dental visit: ____
- Reason for this dental visit: ____
- Does Dental treatment make you nervous or anxious: ☐ Not at all ☐ A little ☐ Moderately ☐ Extremely

Have your ever had any of the following? Please tick those that apply:

☐ AIDS/HIV
☐ Allergies __________
☐ Angina
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Bronchitis
☐ Cancer
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Surgery
☐ Heart Murmur
☐ Hepatitis A B C
☐ High Blood Pressure
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Penicillin Allergy
☐ **Pregnancy**
Due date:__________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ Smoker
☐ Stroke
☐ Sleep Apnoea
☐ Taking Warfarin
Thyroid ☐ Hyperactive
☐ Hypoactive
☐ Tuberculosis

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
  ____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
  ____
- List any medication, supplements or drugs; both prescribed and over the counter that you are taking:
  ____
  ____
- Name of General practitioner: ______________________Phone:__________
- Do you suffer from head aches? ☐ Yes ☐ No
  If yes, where about in the head do you suffer these: ______________________
- Do you clench or grind your teeth? ☐ Yes ☐ No
  If yes, please explain____

Emergency Contact or Next of Kin:______________________ Phone: __________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist at my next appointment.

Signed: ______________________ Date: __________