Welcome to Care 4 Teeth

In order to provide you with safe and efficient dental care, it is necessary to collect the following information from you.We respect your privacy and the information you provide will be kept confidential in accordance to the Privacy Act 2000.

PLEASE FILL OUT THIS FORM IN CAPITAL LETTERS.

PERSONAL DETAILS

Title: **Dr** ☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Master** ☐ **Miss** ☐ | Date of Birth: / /

Surname: | First Name:

Address:

Suburb: | Postcode:

Home No: | Mobile No:

Occupation: | Work No:

Email Address:

MEDICARE/VET AFFAIRS/PRIVATE HEALTH FUND DETAILS

Do you have a private health fund? ☐ Yes ☐ No | Provider Name:

Membership No: | ID No. on Card: (1, 2 3 etc)

Medicare No: | ID No. on Card: (1, 2 3 etc)

Veteran Affairs No:

EMERGENCY CONTACT

Person to contact in case of Emergency:

Relationship to Patient: | Phone Number:

COMMUNICATON

Please select the best method of communication for appointment reminders, promotions and follow up calls.

Email ☐ Letter ☐ SMS ☐ Phone ☐

How did you hear about us?

Referred by: | Signage ☐ Website ☐ Google ☐ Radio ☐

DENTAL HISTORY

When was your last dental visit? | 6 mth ☐ 1yr ☐ 18mth ☐ 5yrs plus ☐

How often (daily) do you brush your teeth? | Once ☐ Twice ☐ More ☐

How often (daily) do you floss your teeth? | Once ☐ Twice ☐ More ☐

Do you have prolonged bleeding after extractions? | Yes ☐ No ☐

Which of the following problems do you experience:

Bleeding Gums	☐	Painful/Sore gums	☐	Swollen Gums	☐	Sharp Teeth	☐
Bad Breath	☐	Sensitivity to Hot/Cold	☐	Grinding teeth	☐	Clenching	☐
Tooth Discoloration	☐	Discolored fillings	☐	Snoring/Sleep Aponea	☐	Clicking/pain	☐
Food Trapped between Teeth	☐	Other (please Specify): ______________	☐				

In what other ways can we help you achieve your dream smile?

____

MEDICAL HISORY – PRIVATE & CONFIDENTIAL

Do you suffer or have you ever had any of the following medical conditions or treatments?

Serious Problem	*Yes*	*No*	*Serious Problem*	*Yes*	*No*
Arthritis	☐	☐	Kidney Disease	☐	☐
Artificial Joints	☐	☐	Liver Disease	☐	☐
Artificial Heart valve	☐	☐	Lung Disease	☐	☐
Asthma/Hayfever	☐	☐	Osteoporosis (Bone Disease)	☐	☐
Blood transfusion	☐	☐	Panic Attacks	☐	☐
Blood disorder	☐	☐	Psychological Disorders	☐	☐
Anemia	☐	☐	Radiation Therapy	☐	☐
Diabetes (Type _________)	☐	☐	HIV/AIDS	☐	☐
Epilepsy	☐	☐	Cancer	☐	☐
Fainting attacks	☐	☐	Rheumatic Fever	☐	☐
Heart Disease	☐	☐	Steroid Therapy	☐	☐
Hepatitis B/C	☐	☐	Stomach Conditions	☐	☐
High Blood Pressure	☐	☐	Stroke	☐	☐
Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Gastric Ulcers	☐	☐	Tuberculosis	☐	☐
Nervous System Disorder	☐	☐	Transplant Organ/Bone Marrow	☐	☐
Other conditions (please provide details):			Mental Health Issues	☐	☐

ALLERGIES – PRIVATE & CONFIDENTIAL

Allergies Known	*Yes*	*No*	*Allergies Known*	*Yes*	*No*
Aspirin	☐	☐	Iodine	☐	☐
Codeine	☐	☐	Latex	☐	☐
Nuts	☐	☐	Panadol / Nurofen (please circle)	☐	☐
Penicillin	☐	☐	Dairy	☐	☐

Other allergies (please provide details):

CURRENT MEDICAL DETAILS - PRIVATE & CONFIDENTIAL

Are you Pregnant? ☐ Yes ☐ No __________ weeks

What medication are you currently taking?

GP DETAILS – PRIVATE & CONFIDENTIAL

Your GP's Name: Contact Number:

GP Address:

Do you smoke? ☐ Yes ☐ No

Acknowledgement and signature

Please be advised that Care 4 Teeth have a **cancellation fee of $50.00** if failing to attend. If you are unable to attend it would be appreciated if you could please advise us as soon as possible 24 hours before your appointment time.

By signing this form you hereby agree and acknowledge that:

(i) You have accurately completed this new patient/medical history form to the best of your knowledge;
(ii) you consent to any treatment agreed upon, to be carried out by the dentist and their staff;
(iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents;
(iv) Full payment is due at the time of service and you agree to cover all costs incurred to recover any outstanding debt for which you are responsible, including debt collectors, legal fees and any cancellation fees that occur.
(Any patient under 18 must have a consenting adult sign on their behalf)

SIGNATURE OF PATIENT: ____ **DATE:** ______________________________