Patient Details / Update

KEWDENTISTRY

Thank you for choosing us for your dental care.

Please complete the following information for our confidential records. If you are experiencing any difficulty in completing any of our forms our staff would be pleased to assist.

PERSONAL DETAILS

Surname	Mr / Mrs / Miss Ms / Dr (Please Circle)	First Name

D.O.B	Age

Home Address	Post Code

Ph. (Home)	Ph. (Work)	Ph. (Mobile)

Fax	e-mail Address

Occupation	Business Firm / Employer

EMERGENCY CONTACT

Name	Relation

Tel (Home or Work)	Tel (Mobile)	Primary Language

MEDICAL PRACTITIONER or PHYSICIAN

Physician's Name	Ph:

HEALTH INSURANCE

Do You Have Dental Insurance? NO ☐ YES ☐

If Yes, which fund? _____

WHO REFERRED YOU TO US

☐ Specialist

☐ Recommendation by a patient or other organization

☐ Outside sign

☐ Advertisement: ☐ TV ☐ The Age ☐ Herald Sun ☐ Radio ☐ Local Newspaper

☐ Internet: ☐ Google or other search engine ☐ Social Media

Other – Please specify: _____

Medical History / Update

It is important that all the questions in this form are answered accurately to assist us in providing the best possible treatment for you and your safety.

ALLERGIES

Are you allergic to Penicillin? NO ☐ YES ☐

Are you allergic to latex (Rubber)? NO ☐ YES ☐

Are you allergic to any other substances, foods or medications? NO ☐ YES ☐

If YES, please state which:

MEDICATIONS

Are you taking any drug, pill or medication? NO ☐ YES ☐

Please list your medications and how you take them:

For your safety, DO NOT omit any information

DENTAL PROSTHETICS

Do you have dentures, crowns/bridges, or loose teeth? NO ☐ YES ☐

If yes, give details:

MEDICAL & HEALTH HISTORY

Please indicate if you ever had or suspect of having any of the following CONDITIONS:

	NO	YES		NO	YES
High Blood Pressure	☐	☐	Asthma	☐	☐
Angina	☐	☐	Chronic Bronchitis	☐	☐
Heart Attack	☐	☐	Tuberculosis	☐	☐
Cardiac Surgery	☐	☐	Diabetes	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐
Endocarditis	☐	☐	Blood-borne Virus	☐	☐
Excessive Bleeding	☐	☐	Immunodeficiency	☐	☐
Stroke	☐	☐	Glaucoma	☐	☐
Epilepsy	☐	☐	Bone Disease	☐	☐
Pneumonia	☐	☐	Scarlet Fever	☐	☐
Anaemia	☐	☐	Gout	☐	☐
Anxiety	☐	☐	Clots/DVT	☐	☐
Mental Illness/Depression	☐	☐	Thyroid Disorder	☐	☐

If you ticked YES to any of the above Conditions or Symptoms, please provide further details:

Do you have an artificial heart valve or other prosthetic implant? NO ☐ YES ☐
If Yes, please provide details:

Ladies, Are you pregnant or breastfeeding? NO ☐ YES ☐
If pregnant, how far:

Do you have any other serious illness? NO ☐ YES ☐
If Yes, please provide details:

RECREATIONAL/SOCIAL HISTORY

Do you smoke? NO ☐ YES ☐
If Yes, how many per day?

How often do you consume alcohol?

☐Never ☐Occasionally/Socially Only ☐ 2-4 times per week ☐ Daily

PRESENTING COMPLAINT

What are your **reasons** for seeking dental treatment and what is concerning you the most?

DENTAL HISTORY

How long since your last check-up?

Are you able to eat and chew all food satisfactorily? NO ☐ YES ☐

Are you satisfied with the appearance of your teeth? NO ☐ YES ☐

Are you experiencing any pain or discomfort with your teeth? NO ☐ YES ☐

Do you get any pain or discomfort with your jaws, jaw joints or face? NO ☐ YES ☐

Do you have headaches, earaches, or neck pain? NO ☐ YES ☐

Do you frequently experience sinus problems? NO ☐ YES ☐

Do you grind or clench your teeth? NO ☐ YES ☐

Any serious trouble associated with any previous dental treatment or anaesthetic procedures? NO ☐ YES ☐

If yes, please explain:

RESPONSIBILITY & CONSENT STATEMENT

For: _____

I have completed this questionnaire to my best knowledge and understand that failure to make a full disclosure may place me (or the above named) at undue medical risk. I also give my consent to procedures, medications or anaesthetics to be administered for diagnostic purposes or dental treatment.
I understand and acknowledge that I am financially responsible for the services provided for my self or the above named, regardless of insurance coverage, medicare benefits or tax refunds.
I agree and accept that I will be liable for a cancellation fee of $140 per ½ hour segment as a minimum plus costs unless sufficient notice is given (48 hours notice is required for appointments of longer than 1 hour). I also understand that any legal and debt collection fees associated with an unpaid account will be at my cost.

Signed ***Date***