ABC dental centre

07 3371 5441
Toowong Terraces
Level 2, Shop 18/31 Sherwood Rd
Toowong QLD 4066
www.abcdentalcentre.com.au

Patient ID No:_____

Dear Patient

Welcome to our surgery. Please take your time to answer these questions as accurately as possible. This will assist us greatly in our effort to provide the best dental treatment for you. All information will be treated with complete professional confidentiality.

Preferred Title:_____
First Name (s): _____ Date of Birth: _____
Surname: _____ Phone (H):_____
Address: _____ Phone (M):_____
Suburb: _____Postcode:_____ Occupation: _____
Email Address: _____
Parent/Guardian (if under 18)
Name: _____ Phone:_____
Address:_____
Relationship:_____ Are you financially responsible for this account?_____
In Case of Emergency, Please Contact:
Name:_____ Relationship:_____ Phone:_____

How did you hear about us? (Please tick one)

Google Search		Sandwich Board		Our Website		Sponsor:_____		Train Station Sign	
Local Business		Flyer		Local		Family/Friends Name:		Health Engine	
Social Media: _____		Health Fund Search:_____		Metro North/South				Other:	

MEDICAL HISTORY

Have you ever had any of the following? **Please tick YES or NO for each condition:**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
AIDS/HIV Positive			Chronic Fatigue/Fibromyalgia			Leukaemia		
Anaemia			Diabetes			Lung Disease		
Angina			Eating Disorders			Migraine/Chronic tension		
Arthritis			Epilepsy			Nervous/Psychiatric Condition		
Artificial Joints			Excessive Bleeding			Osteoporosis		
Asthma			Heart Condition			Pacemaker		
Blood Disease			Hepatitis A, B, C			Radiation Therapy		
Bone Disease			High Blood Pressure			Rheumatic Fever		
BSE/CJD/GSS			Low Blood pressure			Stroke		
Cancer			Kidney Disease			Thyroid disease		

Please give details if you have ticked any of the above:_____
Please list all of your current Medications:_____
Do you have any allergies?_____
Do you require antibiotic cover for Dental Treatment?_____
Are you pregnant?____ If yes, how many months?____ Do you smoke?____ If yes, how many per day?_____
Have you ever had BOTOX or dermal/injectable fillers?_____
When was the last time you visited a Dentist? _____
Private dental Insurance? (BUPA/Medibank/HCF…)_____Member number:_____
What is the purpose of your visit today?_____

PAYMENT

For your convenience we accept EFTPOS, VISA/Mastercard credit cards and HICAPS. Please ensure you bring all required cards to your appointment as **payment is strictly required on the DAY.**

I have answered the Medical History to the best of my ability.

Patient/Guardian Signature:_____**Date**:_____