

*toowong village dental*  
*general, cosmetic & implant dentistry*

**CONFIDENTIAL INFORMATION**

Mr / Mrs / Ms / Miss / Master (please circle)

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Ph: \_\_\_\_\_

Private Health Fund: Yes/No; if Yes, which fund? \_\_\_\_\_

How did you find out about our Practice? \_\_\_\_\_

Do you regularly attend another Dentist? \_\_\_\_\_

**CONFIDENTIAL MEDICAL HISTORY**

Do you currently have, or have you ever been treated for any of the following conditions?

	YES	NO		YES	NO
Recently taken steroids			Joint replacement surgery		
Taking any anticoagulants or bisphosphonates			Bad reaction to local or general anaesthetic		
Allergic to latex materials			Arthritis		
HIV (confirmed or suspected contact)			Epilepsy		
Hepatitis A B C (please circle)			Diabetes		
Rheumatic Fever			Prolonged bleeding after trauma or surgery		
Heart Murmur			Pacemaker		
Heart Attack or other heart problems			Asthma		
Kidney Disease			Bronchitis or other Lung Disease		

Are you receiving treatment from a doctor or specialist? Yes/No

If yes, please advise: \_\_\_\_\_

Are you taking any drugs or medications? Yes/No

If yes, please advise: \_\_\_\_\_

Do you have any known allergies (drugs, food, materials)? Yes/No

If yes, please list: \_\_\_\_\_

Do you smoke? Yes/No

If yes, please advise how many per day and for how many years: \_\_\_\_\_

For female patients, are you pregnant? Yes/No

Are there any other aspects of your health that you feel the dentist should know about?

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## **PERMISSIONS**

Do you give permission for the dentist to take photos of your teeth? Yes/No

Do you give permission for the photos taken to be used in professional presentations? Yes/No

Who is responsible for your fees? \_\_\_\_\_

How will you usually pay for treatment? Cash / Cheque / Visa or Mastercard / Eftpos (please circle)

I acknowledge that fees incurred are due and payable on the day of treatment unless prior arrangement has been made. I understand and accept that collection fees and costs will be applied as required to recover overdue accounts. I understand that 24 hours notice is required to reschedule an appointment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_