WELCOME to IM DENTAL

~ ALL INFORMATION IS PRIVATE AND CONFIDENTIAL ~

For your safety and quality of care, please carefully review this form and fill out areas which pertain to you.

PATIENT'S DETAILS

☐ NEW patient
☐ EXISTING patient/update
■ Date of your last dental visit:
………./………/…………….

GENDER: ☐ Male ☐ Female

Date of birth: …..……/………./……………..…

TITLE: Mr Mrs Ms Miss Master *Other:………………………*

SURNAME: ………………………………… FIRST name: …………….………………. Preferred name: ………………………..…
(PLEASE PRINT) (PLEASE PRINT)

HOME address: ……………………………………………
……………………………………………

POSTAL address: ………………………………………………
………………………………………………

Home phone: ……………………………………..
Mobile phone: …………………………………….
Preferred contact #: ………………………………
Email: ……………………………………………….

Occupation: ……………………………………………………
Employer/business name:……………………………………..
Work phone: ……………………………………………………

Nominated Emergency Contact:

Surname: …………………………………………………..
Relation: ……………………………………………………

First name: ……………………………………………………
Phone: ……………………………..

MEDICAL DOCTOR (GP): ……………………………….. Phone:………………………………

✻ How did you hear about our clinic? *(website, friends, relatives, White Pages, word of mouth etc)*: …………………………………………

ACCOUNT INFORMATION

Person responsible for the account (*signature required*).

☐ **SAME AS ABOVE**
(please sign below)

SURNAME: ………………………………………………… **(IF DIFFERENT TO ABOVE)**

FIRST name: ………………………………………………..

HOME address: ……………………………………………
……………………………………………

POSTAL address: ……………………………………………
……………………………………………

****I hereby authorise assignment of my insurance rights and benefits directly to the provider for services rendered.*
*I fully understand that I am solely responsible for any balance not paid by my insurance company****

……………………………………………
SIGNATURE

INSURANCE INFORMATION

Do you have private health insurance with DENTAL benefits? ☐ YES ☐ NO

Are you eligible for Medicare CHILD DENTAL SCHEME or VETERAN AFFAIRS benefits ? ☐ YES ☐ NO

If yes…

Insurer's name: ……………………………………. Insurance number: ……………………………Line number: …………

PLEASE TURN OVER

DENTAL HISTORY

Reason(s) for TODAY's visit: ....
(exam, broken filling, tooth decay, sensitivity, denture, bridges, crowns, veneers, bleaching etc)

Are you currently experiencing dental PAIN?: .... *If YES*, how long?: ....

☑ *Please TICK any of the following you have had / currently have:*

- ☐ Dental Treatment Anxiety
- ☐ Discomfort / Clicking in Jaw
- ☐ Grinding or Clenching
- ☐ Mouth Blisters / Sores / Ulcers
- ☐ Orthodontic Treatment
- ☐ Periodontal / Gum Treatment
- ☐ Red, Swollen or Bleeding Gum
- ☐ Sensitive to Cold, Hot or Sweet
- ☐ Snoring / Sleep Apnea
- ☐ Trouble with Chewing or Speaking
- ☐ *Complications with Dental Treatment*
- *Other:*...

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive.

☑ *MUST indicate YES or NO for the following*

Do you have any *ALLERGIES* ? ☐ **YES** ☐ **NO**

☐ Latex ☐ Metal ☐ Local Anaesthetic ☐ Acrylic ☐ Penicillin ☐ Sulphur ☐ Aspirin ☐ Codeine Other: ....
....

OSTEOPOROSIS medication or medication containing *BISPHOSPHONATES* ☐ **YES** ☐ **NO**

If yes… ☐ CURRENTLY TAKING ☐ PREVIOUSLY TAKEN

TOBACCO USAGE ☐ **YES** ☐ **NO**

If yes… ☐ CURRENTLY using ☐ PREVIOUSLY used

Number of years: .... Quantity per day: ....

FOR FEMALE PATIENT:
- Are you *PREGNANT* or trying to? ☐ YES ☐ NO
- Are you taking contraceptives? ☐ YES ☐ NO
- Are you breast feeding? ☐ YES ☐ NO

☑ *Please TICK any of the following you have had / currently have:*

- ☐ ***Artificial Heart Valve***
- ☐ ***Artificial Joint***
- ☐ ***Excessive Bleeding***
- ☐ ***Heart Ailment***
- ☐ ***Heart Pacemaker***
- ☐ ***Rheumatic Fever***
- ☐ AIDS / HIV
- ☐ Angina
- ☐ Anorexia or Bulimia
- ☐ Asthma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dialysis
- ☐ Epilepsy or Seizures
- ☐ Haemophilia
- ☐ Hay Fever
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Radiation Treatment
- ☐ Shingles
- ☐ Stomach / Intestinal Disease
- ☐ Stroke
- ☐ Thyroid Problems
- *Other:* ....

Please list any medication you are currently taking: ....
....

- ❖ *We invite you* to discuss with us any questions you may have regarding our services. A Quality Dental Health Service is based on a friendly and mutual understanding between provider and patient.
- ❖ *Our policy requires payment in full for all services rendered at the time of visit.* If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and/or any other expenses incurred in collecting your account.
- ❖ *Our policy: re-scheduling or cancellation* of an appointment must be made with a *minimum of 24 hours notice* to avoid incurring a $30 fee (please note: Monday appointments need to be addressed no later than Friday). *Failure to attend an appointment* will incur a $30 fee.
- ❖ I have completed this form to the best of my ability and understand that providing incorrect information can be dangerous to my health (guardian: patient's health). *It is my responsibility to inform the dental office of any changes in my medical status or personal details.*

SIGNATURE: .... DATE: ..../............./......................
SIGNATURE OF PATIENT, PARENT or GUARDIAN