Medical and Dental Details

BAY OF ISLES DENTAL CLINIC

This form is a medical and dental questionnaire that will become part of your permanent records and provide our practice with the information we need to provide a safe and consistent service according to your individual needs. All information you supply to us will be held in strictest confidence. It is important that you answer **ALL** of the questions regarding your health as it may have a significant effect on the dental care we can provide.

Mr/Mrs/Miss/Ms/Mstr/Dr Date of Birth: _____
Surname: _____

Given Name(s): _____

Address: _____

Surburb:_____ Postcode:_____

Hm Ph:_____ Wk Ph: _____

Mb Ph: _____

Email:_____@_____

Private Health Fund: _____

Member Number: _____

Patient number: 00 / 01 / 02 / 03 / 04 / 05/_____

Emergency Contact Details:

Name: _____

Mobile: _____

Relation: _____

Please let staff know if you have:

☐ Severe dental anxiety / phobia

☐ Private and confidential information that I wish to discuss with the dentist only in a private setting

Signed: Patient / Parent / Guardian

_____

Date: _____ / _____ / _____

Turn over for more information.

Have you been hospitalised or under medical care in the past 12 months ?

☐ NO ☐ YES _____

Have you seen a dentist in the last 6 months? If so, where?

☐ NO ☐ YES _____

Medical Conditions (please tick boxes):	NO	YES
Heart (surgery, disease, attack, murmur)	☐	☐
Heart Pacemaker	☐	☐
Rheumatic Fever	☐	☐
Arthristis/Rheumatism	☐	☐
Asthma/Bronchitis	☐	☐
Blood Disorders/Pressure	☐	☐
Epilepsy/Fits	☐	☐
Chemotherapy/Radiation	☐	☐
Joint/Organ Replacement	☐	☐
Require Antibiotic Cover	☐	☐
Thyroid Disease	☐	☐
Osteoporosis	☐	☐
Excessive Bleeding/Bruising	☐	☐
Cortisone Medicine	☐	☐
Lung Condition	☐	☐
Depression/Anxiety	☐	☐
Diabetes – Type 1 / Type 2	☐	☐
Family History of Diabetes	☐	☐
Hepatitis, Jaundice or Liver Diseases	☐	☐
Infectious Diseases	☐	☐
Smoker / Vape	☐	☐
Currently Pregnant	☐	☐

If yes, how far along? _____

Please list any other medical conditions

_____

_____

_____

_____

Common Allergies (please tick boxes):

Latex:	☐ NO	☐ YES	Antiseptics:	☐ NO	☐ YES
Local anaesthetic:	☐ NO	☐ YES	Penicillin:	☐ NO	☐ YES
Aspirin:	☐ NO	☐ YES	Ibuprofen:	☐ NO	☐ YES
Gluten:	☐ NO	☐ YES	Milk Proteins:	☐ NO	☐ YES

Please list any other **ALLERGIES** : _____

Please list any **MEDICATIONS** you take. If you do not remember the name, please write what you take it for.

_____

_____

_____

_____

_____

_____

Bay of Isles Dental Clinic would like your permission to use images taken to showcase extraordinary before and after smiles on our website, Facebook page and other social media accounts.

Please indicate below the following areas where you consent to the use of your picture.

Please check all that apply.

- ☐ Full face can be shown
- ☐ Teeth only can be shown
- ☐ First name can be used
- ☐ I do not give permission

You also acknowledge that you are not entitled to any remuneration, royalties or any other payment from this dental practice in respect to the use of the photographs.

☐ I ACKNOWLEGDE

- I acknowledge that this represents a true and accurate medical and dental history. I will advise of any changes to my medical and dental history if changes occur.
- I, the undersigned, consent to the performing of dental and oral procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated will assume responsibility for the fees associated with those procedures
- I understand that Bay of Isles Dental Clinic require at least 24 hours' notice if I must cancel or reschedule my appointment and that I will assume responsibility for the $50 penalty fee incurred if I fail to give the necessary notification
- I consent to make a payment in full on the day of my provided dental care. If I do not make payment in full as required I assume the responsibility of penalty fee of $15 per week for ongoing administration costs.
- I accept full responsibility for all legal costs associated with collection of any unpaid amount to DM & CT Dental Pty Ltd. I understand that any unpaid amounts will be subject to credit agency policy and may affect my credit history.

BAY OF ISLES DENTAL CLINIC

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