PERSONAL INFORMATION

Title .... First Name .... Last Name .... Date of Birth ____/____/____

02

Address -- Suburb -- Postcode ------------------------

Phone (Home) -- Mobile --

E-mail Address --

03 Medicare Care Number | | | | | | | | | | | Exp Date | | | | | ID NUMBER | |

04 PRIVATE HEALTH INSURANCE ? YES / NO

Insurance Provider -- Membership Number -- I.D.Number ------------

05 EMERGENCY CONTACT

Name -- Contact Number -- Relationship to Patient ------------------------

DENTAL INFORMATION

06 **Do You Have, Or Have You Ever Had Any Of The Following?**

Cold sores	Yes / No	Neck pain	Yes / No
Oral lesions	Yes / No	Jaw Pain	Yes / No
Sore/bleeding gums	Yes / No	Oral surgery	Yes / No
Mouth swelling/lumps	Yes / No	Orthodontic treatment	Yes / No
Sensitive teeth	Yes / No	Dental implants	Yes / No
Gum disease	Yes / No	Temporomandibular disorders	Yes / No
Difficulty chewing	Yes / No		

07 **Dental Appliances**

Denture	Yes / No	Orthodontic retainer	Yes / No
Mouth guard	Yes / No	Night guard	Yes / No

08 **Have You Ever Had Problems With Local / General Anaesthetic?**

Allergy	Yes / No	Fainting	Yes / No
Difficulty getting numb	Yes / No	Paraesthesia	Yes / No

Other ....

09 **Date of your last dental exam** ... . **Date of your last dental x-ray** ....

MEDICAL INFORMATION

10 **Allergies**

Penicillin/Antibiotics	Yes / No	Morphine	Yes / No
Codeine/Narcotics	Yes / No	Ibuprofen	Yes / No
Aspirin	Yes / No	Latex allergy	Yes / No

Other allergy conditions ....

11 **WARNINGS**

Pregnant or Possibly Pregnant	Yes / No	Bruising or Persistent bleeding	Yes / No
Antibiotic Cover Required	Yes / No	Anything dentist should know?	

12 **Please List ALL Current Medications** ....

....

13	**Habits**				
Do You Smoke ?	Yes / No	Unit per day?	Alcohol ?	Yes / No	Unit Per Week? ....
Chew Tobacco ?	Yes / No		High Sugar Diet ?	Yes / No	
Recreational Drugs	Yes / No		Lots Of Fizzy/ Acidic drinks	Yes / No	

14 **Do You Have, Or Have You Ever Had Any Of The Following Conditions?**

Condition		Condition	
AIDS/HIV	Yes / No	Hiatus Hernia	Yes / No
Anemia	Yes / No	Hepatitis A/B/C	Yes / No
Arthritis	Yes / No	Kidney disease	Yes / No
Artificial Heart Valve / Limbs Or Joints	Yes / No	Liver disease	Yes / No
Angina	Yes / No	Lupus (autoimmune disease)	Yes / No
Asthma	Yes / No	Mental illness	Yes / No
Cancer / Tumor	Yes / No	Osteoporosis	Yes / No
Congenital Heart Defects or Heart murmur	Yes / No	Pacemaker fitted ?	Yes / No
Diabetes Type I	Yes / No	Past Serious or Infectious Disease	Yes / No
Diabetes Type II	Yes / No	Rheumatic Fever	Yes / No
Epilepsy / seizures	Yes / No	Sinus problems	Yes / No
Facial / Jaw Trauma	Yes / No	Sleep disorder/problem	Yes / No
Gastro Reflux or Eating Disoder	Yes / No	Stroke	Yes / No
Heart attack	Yes / No	Thyroid problems	Yes / No
Heart murmur	Yes / No	Tuberculosis	Yes / No
Heart Disease or Heart Sugery	Yes / No	Ulcers	Yes / No

Other --

16 INFORMED CONSENT

* All dental treatment is carried out using up to date techniques, equipment and materials. All equipment is either disposable or sterilised using an autoclave which is validated daily for optimal efficiency.
* It is the policy of this practice to take diagnostic radiographs at the first examination and specific radiographs as required before certain procedures.
* A current periapical radiograph will be taken prior to any extraction. This is for your protection as well as our own.
* Any treatment required will be provided with the patients informed consent after all risks associated with the treatment are outlined.
* All information on this form is considered confidential and is necessary to ensure that the best possible treatment can be provided.
* An estimate of fees will be outlined prior to treatment being provied. If you are not sure of estimated fees, you need to let us know.
* All fees incurred per appointment must be settled at the completion of that appointment.
* Should any account for any reason become outstanding, then the person responsible for the accounts will be responsible for all debt collection charges incurred. I allow the clinic to contact my emergency contact when I cannot be reached in regards to my outstanding debts.
* I allow the clinic to contact my emergency contact when I cannot be reached in regards any outstanding debts.
* I allow the clinic to contact me via SMS and email
* I have accurately completed this pre-clinical questionnaire to the best of my knowledge and agree to the terms of acceptance. I hearby give my authority for any treatment agreed upon by me, to be carried out by the dentist and their staff and I assume full financial responsibility for said treatment.
* I understand that Me dental care requires payment on the day of treatment. Any expenses or costs incurred by Me Dental Care in recovering outstanding monies including debt collection fees will be paid by the parties above.
* I also further acknowledge that failure to attend an appointment without 24 notice may result in a deposit requirement before future appointment will be made and a fee charged for the cancelled appointment.

Patient Signature____ Date ______/______/______