Hastings Family Dental Care

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Welcome to our practice. In order to assist in our administration and determining your treatment, please answer the following as accurately as possible. **All information Strictly Confidential.**

(Mr Mrs Miss Master Ms Other?)

Surname..... First Names.....

Preferred Name..... Date of Birth..... Telephone Home.....

Email..... Work.....

Home Address..... Mobile.....

Suburb..... Postcode.....

Emergency Contact Details

Name..... Relationship..... Telephone.....

Address.....

Suburb..... Postcode.....

Medical History

Have you ever been diagnosed with any of the following?

Rheumatic fever	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Heart Ailment	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Excessive Bleeding	Yes ☐	No ☐	Hepatitis A ☐ B ☐ C ☐	Yes ☐	No ☐
AIDS\HIV	Yes ☐	No ☐	Back Problems	Yes ☐	No ☐	Drug Allergies	Yes ☐	No ☐

Are you allergic to anything? If so please list .....

.....

Do you have an artificial hip, heart valve, or other prosthetic implant? Yes ☐ No ☐

If so please list.....

Have you ever been treated for Cancer or Osteoporosis? Yes ☐ No ☐ (Please State)

Please list any other medical conditions you have or have had.....

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Please list any drugs or medicines you are taking.....

.....

Do you smoke? Yes ☐ No ☐ If so, how many?..... per day .....

Ladies are you pregnant? Yes ☐ No ☐ Maybe ☐

Do you have any special needs? .....

Have you ever had any problems with Dental Treatment? If so please describe.....

.....

PTO

How did you find out about the practice?

☐ Health Fund ☐ Facebook ☐ Google ☐ Walking by ☐ School

☐ Newspaper ☐ Other .....

☐ Family / Friend please specify.....

Are you a member of any health fund? Yes ☐ No ☐

Which Fund?.....

Membership No?..... Patient No?.....

Are you eligible for dental treatment under Veterans Affairs?.....

If so, your number is?.....

Accounts will be itemised with the treatment provided. Rebates on fees differ between health funds and are set by the fund with no consultation with our practice.

Please feel free to discuss any aspects of treatment with us.

Who is your medical doctor?..... Phone .....

Please list any other medical specialists you see .....

Thank you for answering the above questions, please inform us of any changes to this information at future appointments.

In the event of referral to a specialist, consent is given by signing below so that all relevant documents can be forwarded to specialists.

Regularly cancelling appointments at short notice or simply not turning up for an appointment, is unfair on both your treating clinician and other patients who require treatment. To be fair to all at Hastings Family Dental Care we require 24 hrs notice with any cancellation. Failure to do so will result in a cancellation fee. We require payment on the day for all dental services provided at Hastings Family Dental Care. Please note that we do not provide payment plans.

I acknowledge the terms and conditions of this practice and I have answered the above questions to the best of my knowledge.

Signed.....Print Name.....Date.....