TOP RYDE DENTISTS

Professional Health Providers

Please note that all information on this medical/dental form will remain strictly confidential

Mr./ Ms./ Mrs./ Miss.	Phone (H)
Surname:	Phone (W)
Given Name:	Mobile:
Date of Birth:	Email:
Health Funds:	Occupation:
Address:	

Health Insurance Information	Medical Information
Insurance company name:	Medicare number:
Card number:	Reference number:
Reference number:	Expiration date:

In case of emergency Who should we contact?

Relation: ..... Phone: .....

MEDICAL HISTORY

Name of your GP: ..... Phone: .....

Address .....

Have you ever had any of the following? Please tick those that apply:

☐ Anaemia	☐ Heart Disease	☐ Sinus problems
☐ Fainting	☐ Respiratory Problem	☐ Dizziness
☐ Pacemaker	☐ Blood Disease	☐ Jaundice
☐ Artificial joints	☐ Heart Murmur	☐ Stroke
☐ Glaucoma	☐ Rheumatic fever	☐ Epilepsy
☐ Radiation Therapy	☐ Hepatitis A,B,C	☐ Kidney Disease
☐ Cancer	☐ Tumours	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Excessive Bleeding
☐ Psychological	☐ HIV/ AIDS	☐ Liver Disease

Are you currently taking any medications or tablets regularly? If yes, please provide more information.....

Are you pregnant? If yes, how many months?.....

Have you had any serious illnesses in the last 2 years? If yes, please provide more information.....

Do you have any allergies to drugs or food? Please specify.....

Is your blood pressure normal, high or low? .....

Do you smoke?..... If yes, how many per day?.....

DENTAL HISTORY

Name of previous dentist: ..... Date of last visit to dentist ..../..../....
What is the main purpose of your visit today? .....
Does dental treatment make you nervous? .....

How did you know us?

☐Internet/Website ☐Walked past ☐Yellow Pages☐Village Voice
☐Other patients (Please provide name so that we can thank them).
.....

CONSENT FOR SERVICES

☐ I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.

☐ I understand that the practice requires at least **24 hours** notice if I need to cancel my scheduled appointment and that a cancellation fee of **$100.00** could be incurred if I fail to do

☐ I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.

☐ I am aware that payment is required on the day of treatment.
We provide as a courtesy to our patients a preventative recall program that offers a call service if you have not been to the practice in 6 months. Do you wish to receive a phone call from the practice in the event that you have missed your recall?
☐ Yes ☐ No

Patient Signature Date: