TOOTH ZONE
BLACKWOOD

PRE TREATMENT FORM

Welcome to Tooth Zone. We appreciate the confidence you have placed with us to provide your dental care. To assist us in providing you the best possible care, please complete the following details. The information you provide is confidential and will be handled in accordance with our privacy policy. Please do not hesitate to ask if you have any questions.

Please complete the below questionnaire and return to our dental reception. Thank you.

Your Details:

○ Dr ○ Mr ○ Mrs ○ Miss ○ Ms ○ Master

First Name: ______________________________ Surname: ______________________________

Preferred Name: ______________________________ Date of Birth: ___ / ___ / _____ Country of Birth: __________________

Address: ____

Suburb: ____ Post Code: _____________

Home Number: _________________________ Work Number: _________________________ Mobile Number: ___________________________

Email: ______________________________ Occupation: ______________________________

Emergency Contact Person and Mobile Number: ____

GP Doctors' Name and Contact Number: ____

Private Health Insurance Fund: ______________________________ Card Number: ______________________________

Position Number on Card: ____________ Person responsible for payment on the day of treatment: ______________________________

Dental and Medical History:

If you have confidential medical information that you wish to not write down, please tick: ○

Please list any regular medications that you take at present and what they are used for: ______________________________

____

____

____

Please list any known allergies or reactions to any medications or substances (e.g. Latex, Penicillin, Anesthetics):

____

____

Are you being treated for any medical conditions or problems?

○ No ○ Yes, Please provide details below:

____

____

Have you had any surgical procedures in the past 12 months?

○ No ○ Yes, Please provide details below:

____

____

____

Do you have, or have you had any of the following medical conditions? (✔ All that apply) (* Please provide details below)

○ Steroid Therapy
○ Rheumatic Fever
○ Epilepsy
○ Asthma
○ Diabetes
○ Heart Problems*
○ Heart Murmur
○ Cardiac Pacemaker
○ Radiation Therapy
○ Cancer History*
○ Artificial Joints
○ Mental Illness*
○ Kidney Disease
○ Excessive Bleeding / Blood Thinner
○ High / Low Blood Pressure
○ Acid Reflux
○ Sinus Trouble
○ Tuberculosis
○ Thyroid Problems
○ Liver or Kidney Problems
○ Osteoporosis
○ Hepatitis A, B or C *
○ HIV*
○ Other: ______________________________

____

____

Does any of the following apply to you? (✔ All that apply)

○ Does your jaw "click" or hurt?
○ Do your gums bleed when you clean your teeth?
○ Does food ever get jammed between your teeth?
○ Do you think you have bad breath?
○ Have you had periodontal (gum) treatment?
○ Do you feel you grind your teeth?
○ Do you have a dental night guard?
○ Have you had orthodontic treatment?
○ Have you had your bite adjusted?

Do you smoke?

○ No ○ Yes, ______ per day approximately

Are you, or is it possible that you are pregnant?

○ Not applicable ○ No ○ Yes ________ Months

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Purpose of today's visit: ____
____
How long since your last dental visit? ____

Have you had dental X-rays taken within the past 1 year? ○ Yes ○ No

Do you have another family member at our practice? ○ Yes ○ No If so, who? ______________________________

Please let us know how you found out about Tooth Zone: ______________________________

Consent

We value the need to safeguard this information and in accordance with the principals laid down in the privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:
This information will only be used by the treating dentist in order to deliver your care to the highest standard. It will not be disclosed to those not associated with your treatment without your consent except as a provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information. You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times. There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or copying of information.

We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up to date. We will take responsible steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure.

I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Full payment is required at the time of consultation. In the event that bad debt is established the responsible party will be held accountable for the total account balance plus any fees incurred in collection of the debt.

We accept Visa and MasterCard, Eftpos and cash.

Important Cancellation Policy:
At Tooth Zone we dedicate all our time and resources for your particular visit, we do not double book your allocated time. It is our practice policy that we require at least 24 hours' notice prior to your scheduled appointment, otherwise we will charge a cancellation fee of $60 per hour. We thank you for your understanding and cooperation.

Your Signature: ______________________________ **Date: ___ / ___ /20____**