Welcome

Thank you for selecting our dental healthcare team.
Our aim is to provide you with the best dental care!
If you have any questions or need assistance, please ask us and we will be happy to help.

Grange DENTAL CLINIC

PATIENT DETAILS

Title: Dr/Mr/Mrs/Miss/Ms/Master	Date Of Birth:
Surname:	Home Telephone Number:
Given Names:	Mobile Number:
Preferred Name:	Occupation:
Residential Address:	Work Address:
Suburb:	Place Of Work:
Postal Address:	Work Contact Number:

MEDICARE DETAILS

PRIVATE HEALTH INSURANCE DETAILS

Medicare Card Number:	Name Of Fund:
Ref. Number: *(Number Next To Name On Card)*	Membership Number:
Expiry Date:	Id Number: *(Number Next To Name On Card)*

CONCESSION CARD DETAILS *(please circle)*

Pension/Health Care/ Veterans Affairs
Entitlement Number On Card:
Expiry Date:

IN CASE OF EMERGENCY *(closest friend or relative)*

Name:	Relationship To You:
Contact Number:	
Do you have any family members that also attend our clinic? If yes, do you wish to be linked to one account?	

DENTAL HISTORY *(please circle answers where appropriate)*

Reason for your visit today:				
Are you in pain?	Yes	No		
When was your last dental visit?				
How often do you brush your teeth?				
How often do you floss your teeth?				
Are you happy with your smile?	Yes	No		
What sort of toothbrush do you use?	Soft	Medium	Hard	
Do you have any of these concerns?	Bleeding	Sensitivity	Bad breath	Dry mouth
Have you noticed any loose teeth?	Yes	No		
Do you have any earaches or neck pains?	Yes	No		
Do you wear any removable dental appliances?	Yes	No		
Previous Dental Clinic / Dentist:				

MEDICAL HISTORY *(please circle answers where appropriate)*

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you are taking could have an important relationship with the dental treatment you will be receiving. Thank you for answering the following questions.

Are you in good health?
Have there been any changes in your general health within the past year? Yes No If yes please specify
Name of GP
GP's Address and Phone Number
Are you a smoker? Yes No
Please list any prescription / over-the-counter medicines you are currently taking:
ALLERGIES
Do you have any allergies? Yes No Latex, penicillin, local anaesthetic, nuts, etc?
WOMEN ONLY
Are you pregnant or think you may be pregnant? Yes No
Are you nursing? Yes No
Are you taking birth control medication? Yes No

HAVE OR HAVE YOU EVER HAD THE FOLLOWING *(please circle)*

Asthma problems?	Yes	No	Tuberculosis?	Yes	No
Lung problems?	Yes	No	Rheumatic fever?	Yes	No
Heart attack?	Yes	No	Epilepsy?	Yes	No
Heart conditions? If yes specify?	Yes	No	Blood disorders? If yes specify?	Yes	No
Angina?	Yes	No	Leukaemia?	Yes	No
Stroke?	Yes	No	Migraines?	Yes	No
Pacemaker?	Yes	No	Gastrointestinal disease?	Yes	No
Blood pressure?	Yes High	No Low	Haemophilia?	Yes	No
Liver problems?	Yes	No	Fainting spells?	Yes	No
Thyroid problems?	Yes	No	Reflux / heart burn?	Yes	No
Kidney problems?	Yes	No	Stomach Ulcer?	Yes	No
Diabetes?	Yes	No	Sleep disorder?	Yes	No
Arthritis?	Yes	No	Sinus trouble?	Yes	No
Hepatitis?	Yes	No	Cancer? Past or present?	Yes	No
HIV?	Yes	No	Chemotherapy / Radiation?	Yes	No
AIDS?	Yes	No	Osteoporosis?	Yes	No
Eating disorder? If yes specify?	Yes	No	Mental health disorders? If yes specify?	Yes	No

Have you **ever** taken any of the following medications: *(please circle)*

Fosamax Actonel Denosumab Warfarin Pradaxa

Any Other conditions please specify

_____

PRIVACY DETAILS: I_____ accept the conditions as outlined in the **Grange Dental Clinic practice policy**. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I understand that the payment of the account is my sole responsibility and **payment is to be made on the day of treatment**. I undertake to pay any additional debts incurred in recovery for overdue accounts. I understand that **24 hours** notice must be given if unable to attend any appointments. Patients who fail to attend appointments without **any** notice will be charged **$30** per half hour.

SIGNATURE: _____ DATE: _____

PATIENT / PARENT / GUARDIAN