PATIENT HISTORY - ADULT

Welcome to Cardinia Dental.

The information of which you provide, is completely confidential and protected by the provisions of the Federal Privacy Law Legislation. Your assistance in completing our acquaintance form assists us to provide to you dental care of the highest standard.

Surname:...**Title: Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ … **Dr** ☐.. **Other** ☐...................

First Name:...**Preferred Name:**..

Date of Birth:.........../............./...........

Home Address:..

Postal Address:..

Phone Home:..**Phone Work:**...

Phone Mobile:.. **Email:**...

Preferred method of Contact: Please Tick: SMS☐ **Email**☐ **Letter**☐

Dental Insurance Details: Name of Fund:...**Number next to your name:**..........................

Occupation:...**Company**…………………………………………………………

Company Address:……

Medical Doctor:...**Doctor's Phone Number:**..

Doctor's Address:..

Emergency Contact: Name (Person “not” living at your address):..

Relationship (Friend/Relative,etc):..**Phone Number:**...

Address of emergency contact person:..

Do you have Ambulance Cover? YES/NO

Name of person responsible for payment of dental fees:...**Relationship:**......................................

Whom may we thank for referring you to us?..

MEDICALHISTORY

DO YOU / HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE TICK:

Rheumatic Fever	☐	**Hepatitis (Please circle) A, B, C**		**Asthma**	☐
Epilepsy	☐	**Aids/HIV**	☐	**Heart Ailment**	☐
Tuberculosis	☐	**Diabetes**	☐	**Kidney Disease**	☐
High Blood Pressure	☐	**Cancer**	☐	**Liver Disease**	☐
Low Blood Pressure	☐	**Excessive Bleeding**	☐	**Neck/Back Problems**	☐
None of the Above	☐				

List any other illnesses/ conditions:...

Do you have any allergies? (Please List)...

Are you currently under any medical care? (Give Details)...

Please list any ongoing medication you are taking:...

Do you have: any prosthetic implants or artificial heart valves? (Give Details)..

Have you ever had any problems with previous dental visits? YES/NO …...

Female Patients: Are you Pregnant? YES/NO/MAYBE DUE DATE…………………………………………...............

THANK YOU FOR YOUR ASSISTANCE

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk, I understand that I am personally responsible for all services rendered and acknowledge that payment is expected on the day of treatment. All overdue accounts will incur a monthly account keeping fee. In the event an overdue account is referred to a debt collection agency I will be responsible for all additional fees and charges.

Sign:.. **Date:**..