BARRABOOL HILLS FAMILY MEDICAL & DENTAL PRACTICE

So we can ensure we are looking after your needs, please review and complete the following questionnaire.

Mr/Mrs/Ms/Miss/Master/ Dr

Surname:_____ First Name:_____

Middle name:_____ Date of Birth:_____

Address:_____

Postcode:_____. Occupation:_____

Home Phone:_____.Work Phone:_____. Mobile:_____

Email:_____

Person responsible for fees (if not self):_____

Address:_____

Private Health Insurance Fund:_____. Number:_____

Is another member of your family a patient at our practice? O Yes O No

Have you had any of the following medical conditions: (Please Tick?)

Heart Problems	O Yes O No	Allergies to anaesthetics	O Yes O No
Blood Problems	O Yes O No	Allergies to penicillin	O Yes O No
Artificial Joints	O Yes O No	Allergies to medications	O Yes O No
Rheumatic Fever	O Yes O No	Allergies to latex	O Yes O No
Circulatory problems	O Yes O No	Anaemia or other blood disorders	O Yes O No
Radiation Treatment	O Yes O No	Diabetes	O Yes O No
Excessive Bleeding	O Yes O No	Asthma	O Yes O No
HIV/ AIDS	O Yes O No	Hepatitis A B C D E	O Yes O No
Ulcers (Stomach)	O Yes O No	Epilepsy	O Yes O No
Sinus trouble	O Yes O No	Liver or Kidney Problems	O Yes O No
Tumour History	O Yes O No		

If you ticked yes to any allergies, please give details:_____

Are you currently taking any medications? If yes please list:_____

_____

Would you been interested in tooth whitening? O Yes O No

Would you been interested in straighting your teeth? O Yes O No

Do you have any of the following?	O Yes	Do you think you have bad breath?	O Yes
Does your jaw click or hurt?	O Yes	Do your gums bleed when you brush?	O Yes
Do you feel you grind your teeth?	O Yes	Do you experience sensitivity with hot & cold?	O Yes
Have you ever had orthodontic treatment?	O Yes	Does floss ever tear between your teeth?	O Yes
Do you wear a night guard?	O Yes	Does food get jammed between your teeth?	O Yes
Have you ever had gum disease?	O Yes	Do your teeth ever hurt when you bite hard?	O Yes
Have you ever had your bite adjusted?	O Yes	Do you use Betel Nut?	O Yes
Do you bite your lips or cheeks often?	O Yes	Do you Smoke?	O Yes

Name of physician (G.P):_____Phone:_____

Address:_____

For females: Are you pregnant? O Yes. If yes, what is the due date?_____

How long since your last dental visit?_____

How often do you have dental examinations?_____

Previous dental x-rays were taken? O Less than a year ago

O Longer than a year

How were you recommended to this surgery?_____

Consent for treatment:

I hereby authorise the dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. Procedures of $500 or more require 50% deposit prior to treatment commencement. I understand that payment is due at the time of service unless other arrangements have been made and that I am responsible for applied administration, late payment fees, legal costs and commission associated with debt collection. I authorise that this data may be reviewed by team members of the dental practice. I consent to receive phone calls or letters for the purpose of following up of incomplete treatment, recall reminders, debt collection or any reasonable communication regarding my treatment.

*As we set aside more time for your care, please take the courtesy to give at least 24 hour's notice to change an appointment. Missed or cancelled appointments without required notice may result in a fee of $50 being charged.

Patient / Guardian signature:_____Date_____

Thankyou.

For office use only:

Allergies checked: O Present O Absent

Printed Name: Dr_____ Signature:_____Date_____