CLARITY
DENTAL CARE

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Welcome to our practice. In order to assist in our administration and determining your treatment, please answer the following as accurately as possible.

All information is Strictly Confidential

Mr, Mrs, Miss, Master, Ms Other ……Occupation: ……

Surname……..First Name……..……

Preferred Name……Date of Birth…….....…Telephone Home……..……

Email……Work…….....…....

Postal Address……Mobile…….....

Suburb……Postcode…….....

Emergency Contact Details

Name……..Telephone……..…....

Suburb……Postcode…….....

Relationship: ……

Medical History

Have you ever been diagnosed with any of the following? **(please tick either YES or NO to all)**

Asthma	Yes ☐	No ☐	**Drug Allergies**	Yes ☐	No ☐	**High Blood Pressure**	Yes ☐	No ☐
Aids/ HIV	Yes ☐	No ☐	**Hepatitis A, B or C**	Yes ☐	No ☐	**Back Problems**	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	**Kidney Disease**	Yes ☐	No ☐	**Excessive Bleeding**	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	**Heart Ailment**	Yes ☐	No ☐	**Rheumatic Fever**	Yes ☐	No ☐

Please list any drugs or medicines you are taking……

……

Are you **allergic** to anything? If so, please list……

Do you have any artificial joints, heart valve, or prosthetic implants? YES ☐ NO ☐

If yes, when and what type?……

Have you ever been treated for Cancer or Osteoporosis? YES ☐ NO ☐

If yes, when and what type?……

Please list any other medical conditions you have or have had

……

Do you smoke? YES ☐ NO ☐ If so, how many per day?……

Who is your Medical doctor/clinic?……**Phone**……

Ladies, are you Pregnant? YES ☐ NO ☐ Maybe ☐

Have you ever had problems with Dental Treatment? If so, please describe……

…… **Please Turn Over**

How did you find out about the practice?

☐ Health Fund ☐ Internet ☐ Walking by

☐ Facebook ☐ School ☐ Yellow Pages

☐ Family/ Friend (please specify, so that we may thank them)

……

☐ Other (please specify) ……

……

Are you a member of a health fund with **DENTAL COVER**? YES ☐ NO ☐

If so, then what fund? ……

Are you eligible for dental treatment under **Veterans Affairs**? Yes ☐ No ☐

If so, what is your number? ……

If your **child** receives the **Child Dental Benefit Schedule** please provide their Medicare number……

Accounts will be itemised with the treatment provided. Rebates on fees differ between health funds and are set by the fund with no consultation with our practice. Please feel free to discuss any aspects of treatment with us.

Do you have any special needs or requirements that may assist us in your treatment?

……

Thank you for answering the above questions please inform us of any changes to this information at future appointments.

In the event of referral to a specialist consent is given by signing below so that all relevant Documents can be forwarded to specialist.

Regularly cancelling appointments at short notice or simply not turning up for an appointment is unfair on both your treating clinician and other patient who require treatment. To be fair to all at Clarity Dental Care we require 24 hours' notice with any cancellation. Failure to do so will result in a cancellation fee of $50 for every 30-minute appointment time. We require payment on the day for all dental services provided at Clarity Dental Care. **Please do <u>NOT</u> agree to treatment that you do not have the funds to pay for.**

I acknowledge the terms and conditions of this practice and I have answered all of the questions to the best of my knowledge.

From time to time Clarity Dental Care may send you promotional material via text and/or email. Please tick this box ☐ if you **do not** wish to receive these messages.

…… ……..

Signed Date: