UC DENTAL
UPPER COOMERA

Patient Information Form

(Please complete and return to our receptionist)

Welcome to our practice!

Title: ___________ First Name: ________________________ Surname: _______________________

Preferred Name: _______________________ Date of Birth: ________________ Gender: M / F

Address: ____

Suburb: ____________________________ State: ___________________ Post Code: _____________

Mobile: _____________________ Home Ph: __________________ Work Ph: _________________

Email: ____

Occupation: ____

Do you belong to a health fund? Y / N Fund Name: ___________________________

Person responsible for fees (if not self): ____

Person to contact in case of emergency: Name _________________ Ph: _______________________

Are you Aboriginal or Torres Strait Islander Y / N

Is English your first spoken language? Y / N
(If no please list preferred language: __________________________)

How did you hear of our practice? ☐ Facebook ☐ Staff ☐ Shopping Centre ☐ Google

☐ Health Fund ☐ Internet ☐ Friend/Family ☐ Other ....

Name of person who referred you ....
(We have a rewards program)

G.P Name: __________________________ Phone No: ______________________

Do you normally require antibiotic cover before Dental treatment? Y / N
Have you had any abnormal reactions to local or general anaesthesia? Y / N
Do you Smoke? Y / N
Ladies, Are you pregnant? If yes, date due: _________ Y / N
Are you being treated by a doctor at present? Y / N
Are you taking **any prescription or other** medications at present? Y / N
Please list: ____
Have you been hospitalized within the last 12 months? Y / N
Please list any allergies (Drugs, medicines and including latex, foods and preservatives):

Have you ever had an adverse reaction to any medications? Y / N
Please specify: ____

PAYMENT WILL BE REQUIRED ON THE DAY OF TREATMENT

PLEASE TURN OVER THE PAGE

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this *(please tick box).* ☐

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Please tick either yes or no for each condition

	YES	NO		YES	NO		YES	NO
Steroid Therapy			Kidney Disease			Prosthetic Implant e.g. artificial hip		
Rheumatic Fever			Excessive Bleeding			Bone disease, including osteoporosis		
Epilepsy			Stroke			Stomach or digestive condition		
Asthma			Cancer			Hepatitis A,B or C. Liver diseases (please circle)		
Diabetes			Radiation/Chemo Therapy (circle)			Contact with blood-borne viruses		
Heart disorder/complaint			Thyroid Disease			Bronchitis, emphysema or other lung diseases (please circle)		
Cardiac Pacemaker			Nervous or psychiatric condition			Anaemia, leukaemia or other blood diseases (please circle)		
Tuberculosis			High or low blood pressure: (circle)			Have you had Botox or Dermal fillers? (please circle)		

If you answered yes to any of the above please specify any details:

____

Any other condition(s) not mentioned *(please list):*

____

When did you last see a dentist & what treatment did you have?

____

On a scale of 1-10, how would you describe your level of anxiety about your visit today?

Least anxious ☐1 ☐ 2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Most Anxious

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

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Payment

All emergency dental services, or any dental services performed, must be paid for at the time services are performed. We accept cash, EFTPOS and all major credit cards. Fees may also be paid for missed appointments or appointments cancelled without two working days' notice.

For all patients

I hereby authorise the dentist to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorise and consent to the dentist choosing and employing such assistance as he/she deems fit. I also understand that prior to treatment a full explanation of the procedure(s) involved will be given by the dentist and/or staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls, SMS or email as indicated on this form. I also understand that should my account become delinquent, my information may be released to a third-party collection agency to assist with collecting fees associated with treatment rendered in this office.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change to my health I will inform the dentist at my next appointment without fail.

I have read the above conditions of treatment and agree to their content.

Signature: _____________________________________ Date: ________________________

(Patient / parent / guardian)