Advanced Dental Centre PTY LTD

# PATIENT INFORMATION FORM

**Title:** ..... **Name(s):** ..... **Surname:** ..... **Preferred:** .....

**Date of birth:** / / **Sex:** M ☐ F ☐ Unspecified ☐ **Occupation:** .....

**Address:** ..... **Post Code:** .....

**Telephone: Home:** ..... **Work:** ..... **Mobile:** .....

**Email:** .....

**I consent to being contacted by email and/or SMS for patient reminders and to receive information about the practice** YES ☐ NO ☐

**I consent for a facial recognition photo to be taken for the purpose of patient identification** YES ☐ NO ☐

**Emergency Contact: Name:** ..... **Phone:** .....

**How did you find out about us?** ☐ Referred by: .....
☐ Other .....

**Private Health Fund (Dental Cover):** ..... **Member No:** ..... **Individual No:**.....

**Medicare Card Number:** ..... **Individual No:** .....

**GP's Name:** ..... **Address:** .....

**Are you taking any medications or natural supplements?** YES ☐ NO ☐ If YES, please specify which type and reason:

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**Are you allergic to anything?** ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other .....

**Do you have or have ever had any of the following conditions?** (*Please circle*)

1. Heart Problems YES / NO
   If YES, please specify .....
2. Liver problems YES / NO
   If YES, please specify .....
3. Kidney trouble YES / NO
   If YES, please specify .....
4. Do you have a Pacemaker? YES / NO
   If YES, when was it placed .....
5. Cancer What type ..... YES / NO
   Last treatment of Radiation/Chemotherapy .....
6. Diabetes YES / NO
   Type 1 ☐ Type 2 ☐
7. Rheumatic Fever YES / NO
8. Epilepsy YES / NO
9. Fainting YES / NO
10. Asthma YES / NO
    Do you carry an inhaler? YES / NO
11. Do you smoke? YES / NO
    If YES, how many per day? .....
12. Hepatitis YES / NO
    A ☐ B ☐ C ☐ Other .....
13. Lung disease YES / NO
    If YES, please specify .....
14. Have you had any joint replacements? YES / NO
    If YES, when were they placed .....
15. Do you have any blood disorders such as anaemia? YES / NO
    If YES, please specify .....
16. Females - are you currently pregnant? YES / NO
    How many weeks/months? .....
17. Have you been hospitalised in the last 12 months? YES / NO
    If YES, please specify .....
18. Do you have HIV/AIDS? YES / NO
19. High Blood Pressure? YES / NO
20. Do you have Osteoporosis? YES / NO
    Are you given medication/injections? YES / NO
    If YES, please specify .....

Do you have any disease, condition, or problem not listed above? (e.g. Malignant Hyperthermia) that you think we should be aware of? YES / NO If YES, please specify .....

Do you require antibiotic cover for dental treatment? (e.g. joint replacement or heart condition) YES / NO

***Advanced Dental Centre Pty Ltd requires payment of your account in full at the time of treatment and may charge an appointment cancellation fee if 24 hours notice is not given. During dental treatment, there is a small risk of patients swallowing or inhaling a foreign body. This is because of the difficulty in handling small instruments and other objects while working in the restricted area of the mouth, coupled with being treated while lying back. If a small object is swallowed or inhaled radiographs and surgery may be required to remove the object safely. As I am seeking private treatment, I understand that payment of the account is my responsibility. I undertake to pay any additional expenses incurred in recovering overdue accounts. (If patient under 18 years, person financially responsible to sign below).***

**Name:** ..... **Signature:** ..... **Date:** / /

**PTO →**