CITY GARDENS DENTAL

INFORMATION AND CONSENT FORM

Surname: ....

Given Names: ....

Title: Mr / Mrs / Ms / Miss / Mast / Dr **DOB:** ....

Address: ....

Phone home: .... **mobile:** .... **work:** ....

Email: .... **Occupation:** ....

Name of person responsible for this account: ....

Private dental health cover provider: ....

Who referred you to this practice? ....

How long since your last dental visit? ....

Please circle any dental concerns you have:

- Tooth ache
- Worn/ broken teeth
- Sensitive teeth
- Decay
- Missing teeth
- Dental phobia
- Sports Mouth Guard
- Grinding
- Bleeding gums
- Bad breath
- Dry mouth
- Discoloured teeth
- Cosmetic / appearance concerns
- Crowded/ crooked teeth
- Other (please give details):

....

Please circle any of the following medical conditions which apply to you:

- High Blood Pressure
- Pregnant
- Heart problems or defects
- Pace maker
- Rheumatic fever
- Any artificial heart valves
- Kidney or Liver Disease
- Snoring/ Sleep Apnoea
- Other (please give details):
- Stomach or Bowel problems
- Hip or other prosthetic implants
- Diabetes
- Excessive Bleeding/ Blood disorders
- Asthma
- Arthritis
- Epilepsy
- Hepatitis
- HIV/ AIDS

....

Please list any other medical conditions/ current medical treatment not covered above:

....

....

Please List any medications you are taking currently: ....

....

....

Do you have any allergies (eg: Penicillin, Codeine or Latex)? ....

Medical Doctor's name and phone number: ....

Next of Kin emergency contact name: ....

phone number:.. relationship:..

Are you currently a smoker? ....

We remind our patients of their appointments. Please circle your preferred means of contact

- SMS
- Mobile
- Work phone
- Home phone

We require 24 hours notice to cancel or change an appointment, or a cancellation fee will apply. All treatment is to be paid for on the day.

We do provide a HICAPS facility. However if the health fund rebate is unable to be processed we will require full payment.

I have accurately completed this questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me to be carried out by the dentists and their staff and I take full financial responsibility for treatment.

Signed: ....

(Guardian for patient under 18yrs) Name: ....

Date:..