

# INFORMATION AND CONSENT FORM



City Gardens  
**DENTAL**

ABN: 36 004 417 451  
Ph: 0260 216141 www.cgdental.com.au  
Suite 1 Level 4, 470 Wodonga Place, Albury NSW 2640

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

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

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