DENTAL EXCELLENCE

CONFIDENTIAL PATIENT INFORMATION
Welcome to Dental Excellence
Thank you for choosing us to care for you.

We know that most people dislike filling out forms. We ask you to understand that the following information is required to manage your dental records and accounts, and to provide treatment for you in a safe manner. This information is confidential and will not be made available to any other individual, entity or organisation without your consent, in keeping with the provisions of the privacy act 1993.

PERSONAL DETAILS

First Names		Surname	Title
Gender M / F / other		Date of Birth	
Home Address			
Suburb	Town/City		Postcode

PLEASE ENTER DETAILS BELOW THEN CIRCLE YOUR PREFERRED MEANS OF CONTACT DURING BUSINESS HOURS:

Home Phone:	Mobile:	Work Phone:
Email Address		

Next of Kin name + Phone number:

Who referred you to us?	
School	…or Occupation
Previous Dentist (new patients only)	

MEDICAL HISTORY
YOUR DENTIST MAY DISCUSS THIS FURTHER WITH YOU

1. Name of Doctor/Medical Practice: _____
2. Are you taking **any** prescription or non-prescription medication, pills or inhalers? If **yes** please list:

   _____
3. Have you ever had any allergies or ill effects to **any** medicines, local anaesthetics or other substances (such as latex)? If **yes** please list:

   _____
4. Have you suffered from any of the following (if **yes** please circle)

Heart murmur / other heart trouble / stoke	TB or other infectious disease
Rheumatic fever	Diabetes
High or low blood pressure	Epilepsy
Asthma	Stomach / duodenal ulcers / reflux
Chest lung / breathing problems/ Sleep Apnoea	Sinusitis / hay fever
Are you a smoker?	Eczema
Bruising / bleeding problems	Depression / anxiety

5. Do you have any artificial or prosthetic joints? If **yes** please specify: _____
6. Are you or have ever had contact with HIV, Hep A, B or C viruses? If **yes** please circle.
7. Have you ever been given, or are you currently taking a Bisphosphonate drug (e.g. Fosamax) YES / NO
8. Have you ever received treatment for cancer or had any radiotherapy treatment? YES / NO
9. Females only - Are you pregnant / or breastfeeding? YES / NO If pregnant how many weeks?

I confirm that the information written above is true and accurate to the best of my knowledge.

Signed:_____ **Date:**_____

Terms of Trade
Fees for goods and /or services are payable in full at the time of delivery. By accepting treatment or services at this practice, you agree to these terms and further agree to meet any additional costs incurred by Dental Excellence in the recovery of your outstanding account. You also consent to the passing of information to credit agencies if you fail to comply with these terms.