CENTRAL DENTISTS
SPRINGFIELD LAKES

## Personal Details

| | | |
|---|---|---|
| Title: Mr/ Mrs/ Ms/ Miss/ Master/ Dr | Sex: Male/ Female | D.O.B: |
| Surname: | First Name: | Preferred Name: |
| Home Phone: | Mobile: | Work Phone: |
| Emergency Contact: | Emergency Phone: | |
| Address: | | Post Code: |
| Suburb: | | State: |
| Email: | | |
| Occupation: | Company: | |
| Healthfund: | Membership Number: | #: |

## Medical History

| | | |
|---|---|---|
| Have you ever been hospitalised? □ Yes □ No | When? | |
| Reason: | | |
| Are you on any Medications (including the contraceptive pill)? □ Yes □ No<br>Please list: | | |
| Are you currently under the care of a Doctor? □ Yes □ No | Reason: | |
| Do you have any known allergies? □ Yes □ No<br>Please List: | Are you a smoker? □ Yes □ No<br>How long have you smoked for? | |
| Have you had joint replacement surgery? □ Yes □ No / When? | Are you pregnant? □ Yes □ No<br>How far along? | |

Have you ever suffered from ( tick all that apply):

| | | | |
|---|---|---|---|
| Epilepsy | □ | Diabetes | □ |
| Rheumatic Fever | □ | Asthma | □ |
| High/ Low Blood Pressure | □ | Prolonged Bleeding | □ |
| Heart Conditions | □ | HIV/AIDS | □ |
| Blood Disease | □ | Hepatitis | □ |

| | |
|---|---|
| Do you require Anti-biotic cover? □ Yes □No | Other: |

## Questionnaire

How did you hear about us?

How do you feel about seeing a dentist?

How would you like to improve your smile?

How long has it been since your last dental visit?

***We require 48 hours' notice when cancelling or rescheduling appointments, failure to provide sufficient notice will result in a $50 fee per 15mins you were scheduled for treatment. A text message reminder will be sent to you 24-48hours before your appointment. All payment must be made in full at the conclusion of the appointment. Please note that patient information is required by law to be updated every 6 months, however, it is your responsibility to let us know if of your personal or medical details change in the meantime. Thanks.***

***By signing below you acknowledge that you have read and agreed to the above stated conditions.***

**SIGN:** _____ **DATE:** _____

**ASK US HOW YOU CAN SAVE ON YOUR DENTAL TREATMENT WITH OUR MEMBERSHIP!**