Maroubra Family Dental

COSMETIC • FAMILY • EMERGENCY DENTAL CARE

9344 4888 DR EMMANUEL PERTSOULIS and ASSOCIATES

Welcome to Maroubra Family Dental. Please take a few minutes to fill out this form as accurately as you can.
All information is completely confidential. *If you have any questions, please let us know.*

PATIENT INFORMATION

☐ **Mr** ☐ **Mst** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Dr**

First Name:	**Wishes to be called:**
Surname:	**Date of Birth: _____ / _____ / _____**

Home Address:

_____

Suburb: _____ Postcode: _____ State: _____

E-mail Address:

Home Phone:	**Mobile Phone:**
Work Phone:	**Occupation:**

How did you hear about our practice?
Name of the person who referred you: _____

Is another member of your family a patient at our surgery? ☐ Yes ☐ No

Name: **Relationship:**

EMERGENCY CONTACT

Name of Parent/Guardian/Other to contact in case of emergency:

Relationship to patient:	**Phone:**

Address:

HEALTH INSURANCE INFORMATION

Are you a Veteran Affairs Card Holder? ☐ Yes ☐ No **DVA Card number:**

Medicare card number: **ref no:**

Are you in a Health Fund? ☐ Yes ☐ No **Health Fund Name:**

Membership number:	**Individual reference number:** **(Number next to name)**

CONSENT FOR TREATMENT

1. I hereby authorise the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids if deemed appropriate by the doctor and agreed by me, to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorise the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to be responsible for **payment** of all services rendered on my behalf or my dependants. I understant that payment is **due at the time of service** unless other arrangements have been made. If required, I also understand a check of my credit history may be made.

Patient / Guardian Signature: _____ Date: _____

Patient Name: _____ ☐ Date: _____

☐ Updated

DENTAL HISTORY

Please place a tick in the boxes if you have, or have ever had:

□ Loose teeth/broken fillings
□ Discoloured teeth
□ Sensitivity to cold/heat/pressure
□ Trauma to teeth
□ Food collection between teeth
□ Bad breath
□ Bleeding or swollen gums
□ Dry mouth
□ Grinding teeth
□ Jaw pain
□ Clicking or popping jaw
□ Past orthodontic treatment

MEDICAL HISTORY

Name of your Doctor/GP: **Phone:**

Please place a tick in the boxes if you have allergies to any of the following:

□ Latex
□ Metals (e.g. nickel)
□ Dental anaesthetics
□ Penicillin
□ Erythromycin
□ Tetracycline
□ Aspirin
□ Codeine
□ Antiseptics
□ Other allergies: _____

Please place a tick in the boxes if you have, or have ever had:

□ Bleeding abnormally, with extractions or surgery
□ Anaemia
□ Osteoporosis
□ High/Low Blood Pressure
□ Artificial Heart Valves/Pacemaker
□ Artificial Joints
□ Congenital Heart Lesions/Heart Murmur/Heart problems
□ Rheumatic Fever
□ Cancer, Type: _____
- Treatment: □ Chemotherapy □ Radiotherapy, Date: ____/____/_____
□ Cortisone Treatments
□ Anxiety/Depression/Psychiatric Care
□ Arthritis, Rheumatism
□ Asthma, Use inhaler □ Yes □ No
□ Diabetes, Type: ____
□ Thyroid problems
□ Dizziness
□ Epilepsy
□ Glaucoma
□ AIDS/HIV
□ Hepatitis, Type: ____
□ Kidney Disease
□ Liver Disease, Jaundice
□ Snoring
□ Daytime sleepiness
□ Sleep apnea

Please list any medications you take for the indicated conditions above:

_____

_____

Please turn over if you require more space

Have you had any serious health problems in the last year? ☐ Yes ☐ No

Please give details:

Are you a smoker? ☐ Yes ☐ No – if you have quit, how long ago?

(Women) If pregnant, how many weeks? **Are you breastfeeding?** ☐ Yes ☐ No

Is there anything that we should know about that you would like to discuss privately and confidentially with the dentist? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient / Guardian Signature: _____ **Date:** _____