INNISFAIL DENTISTS HEALTH HISTORY

To ensure we are looking after your needs, please complete the following questionnaire. If you would like to know more about why we collect this information and what we do with it, you can read our privacy policy at www.innisfaildentists.com.au

Surname_____ Title (Mr/Mrs/Miss/Ms/Dr) _____

Given Name/s_____ Gender (please circle) M F

Postal Address _____ Date of Birth _____ /_____ /_____

_____ Home Phone _____

Home Address_____ Work Phone _____

_____ Mobile _____

Email _____

Occupation _____

Emergency Contact Person _____Phone_____

Doctor's Name _____

Dental Insurance Company (Health fund) _____

Is another member of your family a patient at our office? _____

Have you had any of the following?

	Yes	No
Any heart problems	☐☐	☐
Blood pressure (high/low)	☐☐	☐
Allergies to anaesthetics	☐☐	☐
Allergies to medications	☐	☐
Allergies to latex	☐	☐
Diabetes	☐☐	☐
Hepatitis: A B C D E	☐☐	☐
Artificial joints	☐	☐
Rheumatic fever	☐	☐
Radiation treatment	☐	☐
Excessive bleeding/bruising	☐	☐
Asthma	☐	☐
Ulcers (stomach)	☐☐	☐
Epilepsy	☐☐	☐
Tumour history	☐☐	☐

Are you currently taking any drugs or medicines? ..... ☐ ☐

If so please list: _____

_____

..... continued ⇨

INNISFAIL DENTISTS HEALTH HISTORY

Dental Concerns Yes No

Is there anything else you would like us to know? …… ☐ ☐

_____

_____

Who was your previous dentist? _____

Are you pregnant?_____ Due Date: _____

How long since your last dental appointment?_____

Referral - How do you know about Innisfail Dentists?

Website	☐	Phone book	☐
Street signage	☐	Radio advertisement	☐

Or…who can we thank for referring you? _____

Consent for Treatment

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

2. Upon such diagnosis, I authorise the dentist 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 the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature: _____Date _____

Patient's Name: _____

Parent/Guardian signature: _____Relationship to patient _____

WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE
WE ACCEPT VISA, MASTERCARD, PERSONAL/BANK CHEQUE, EFTPOS AND CASH

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