New patient questionnaire

All information you give is kept confidential

unley park
DENTAL CLINIC

Title (Mr, Mst, Mrs, Ms, Miss, Dr)

Surname: First name/s:

Address: Postcode:

Telephone (home): (work): (mobile):

Date of birth: / / Email:

Occupation: Health fund:

Emergency contact person: Contact phone no:

Person responsible for payment:

How did you discover us?

Have you had any of the following?

☐ Heart Problems
☐ Blood Pressure
☐ Joint Replacement
☐ Abnormal Bleeding
☐ Gastric Reflux
☐ Stroke
☐ Thyroid problems
☐ Osteoporosis
☐ Cancer
☐ Allergies to Anaesthetic
☐ Allergies to Penicillin
☐ Allergies to Medication
☐ Allergies to Latex
☐ Anaemia or Blood Disorder
☐ Diabetes
☐ Asthma
☐ Hepatitis
☐ HIV
☐ Epilepsy
☐ Liver kidney problems
☐ Smoker
☐ Other:

Ladies: Are you pregnant?
☐ Yes ☐ No

Are you currently taking any medication/tablets? Please List:

Name of your doctor:

Address and Phone No:

When Was Your last Dental Examination? / /

Are you Happy with Your Smile/Teeth? ☐ Yes ☐ No

Do You Consent to the sensible use of x-rays? ☐ Yes ☐ No

Does Attending the Dentist create Anxiety for you? ☐ Yes ☐ No

CREDIT TERMS 1. Accounts will be issued after each visit. Payment for dental treatment is to be made at the conclusion of each visit, unless other arrangements are made with the dentist. 2. An administration fee may be charged on overdue accounts. 3. Any costs or legal fees incurred in the collection of outstanding accounts are the responsibility of the account payer.
MISSED APPOINTMENTS: Your appointment times are reserved exclusively for you. We require 48 hours notice of changed appointments where possible. **Appointments missed or cancelled at late notice will attract a FEE of $150.00.**

Your Signature (or Parent/guardian if under 18): Date: / /