ARTHUR STREET Dental

phone 02 6652 1677 | fax 02 6652 4745
address 3/14 Arthur Street (North Entrance Plaza) Coffs Harbour NSW 2450
email reception@arthurstreetdental.com.au | web arthurstreetdental.com.au

Dr/Mr/Mrs/Ms/Miss

First Name/s:.....Preferred Name:.....

Surname.....Date of Birth...../...../.....

Address:.....

Suburb: ..... State:.....Postcode: .....

Email:.....

Phone:

(H): ..... (W): ..... (M): .....

Preferred contact method (Please circle): ***Phone call*** OR ***SMS Text***

Health Insurance Provider (if any):.....Line Number:.....

Occupation: .....

Name of Family Dr: ..... PH: .....

Person responsible for fees (if not self): .....

Emergency contact: ..... PH: .....

Parent/ Legal Guardian name/s and contact numbers (if under 18 years old):

.....

Are you Aboriginal or Torres Strait Islander? Y/N.

Is English your first language? Y/N Do you require an Interpreter? Y/N

Are you physically or mentally impaired? Y/N

Are you deaf? Y/N Do you require an Interpreter? Y/N

Referred by: Website/ Google Search/ Facebook/ Instagram (please circle)

Family/ Friend (please tell us who): .....

Have you ever had or are suffering from any serious illness.....

.....

Please circle if you have any of the following:

Heart problems	***Excessive Bleeding***	***Rheumatic Fever***
Osteoporosis	***Diabetes***	***Asthma***
Hepatitis	***HIV/ AIDS***	***Reflux***

Blood pressure: High/ Low/ Normal

Are you taking any medications (drugs, pills etc) at present (please specify)

.....

Are you allergic to any medications (Penicillin, Codeine, Sulphur, Latex etc?)

.....

Are you pregnant? Y/N If so, due date: ...../...../.....

Dental Health History

Do you experience sensitivity with hot/ cold? Y/N

Does food get jammed between your teeth? Y/N

Do you smoke? Y/N

Do your gums ever bleed when you clean your teeth? Y/N

Have you ever had periodontal (gum) treatment? Y/N

Are you missing any teeth? Y/N

Do you feel nervous about having dental treatment? If so, what is your biggest concern?.....

Please note any further concerns: .....

.....

When was your last visit to the dentist/ How long since your last dental x-rays? .....

.....

Consent for Treatment

1. *Upon 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.*
2. *I agree responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service.*

FULL FEE PAYMENT IS REQUIRED AFTER YOUR APPOINTMENT

PLEASE GIVE US THE COURTESY OF 48(BUSINESS)HRS IF YOU NEED TO RESCHEDULE.

YOUR LATE CANCELLATION MAY ATTRACT A FEE OF $100 AND A DEPOSIT MAY ALSO BE REQUIRED TO SECURE YOUR NEXT DENTAL APPOINTMENT.

Signature.....Date ...../...../.....

Thank you for your cooperation

All information supplied is for us only (regarding dental treatment) this is a confidential questionnaire.