WELCOME TO ARTHUR STREET DENTAL

Dr/Mr/Mrs/Ms/Miss

First Name/s:……..…….....

Preferred Name:……..……..…….…….……

Surname..……..……..

Date of Birth ……...…/……..…/…….……..…….……

Address:…….……..……..

Suburb: …… State:..……Postcode: ……

Email:…….

(Home): …… ..(Work): ……. (Mobile): ……..…….

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

Health Insurance Provider (if any): ……..……

Membership Number: …….…….....

Health Insurance 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.

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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

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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?
……..…..
……
……..……

Photo/Video Consent

☐ I consent to Arthur Street Dental taking clinical photographs and/or videos for my dental records and treatment planning.

☐ I consent to the use of de-identified photographs/videos for education or marketing purposes.

☐ I do not consent.

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. 2. I accept responsibility for payment of services provided for myself and/or my dependants. Payment is required on the day of treatment unless prior arrangements have been made.

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PLEASE PROVIDE AT LEAST 48 BUSINESS HOURS' NOTICE IF YOU NEED TO RESCHEDULE OR CANCEL. LATE CANCELLATIONS OR MISSED APPOINTMENTS MAY INCUR A $100 DEPOSIT TO SECURE FUTURE BOOKINGS.

Signature……Date ……/……/…….

Thank you for your cooperation

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