PRE TREATMENT DETAILS

dentistry on unley
Quality care for every individual

Welcome to Dentistry on Unley. We appreciate the confidence you have placed in us to provide your dental care. To assist us in providing the best possible care, please complete the following details. Please don't hesitate to ask if you have any questions. Thank you.

1. Your Details

Full Name: _____
Title First Name Middle Name Surname

Preferred Name: _____ Birth Date: _____/_____/_____

Address: _____

Suburb: _____Post Code: _____

Telephone: Home _____ Work _____

Mobile _____ Email: _____

Occupation: _____

Emergency contact: Name: _____ Phone: _____

2. Payment Information

Name of Private Health Fund (Extras): _____

Card No. _____ Position No. on Card: _____

Person responsible for payment on the day of treatment: _____

3. How you found us

Do you have another family member at our practice: ❑ Yes ❑ No

If so, who? _____

Please let us know how you found out about Dentistry on Unley:

❑ Yellow Pages
❑ Media Advertising
❑ Google Search
❑ Dentistry on Unley website
❑ Word of Mouth / Personal Referral
❑ Facebook
❑ Health Engine
❑ Other _____

Who may we thank for referring you? _____

4. Dental and Medical History

Purpose of today's visit? _____

_____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental radiographs last taken: Less than 1 yr ❑ Longer than 1 yr ❑

Are you currently taking any medicines or other drugs (including natural medicines)?

If so, please list: _____

_____

_____

Have you had any of the following?

	Yes	No		Yes	No
Heart Problems:	❑	❑	Allergies to Anaesthetics:	❑	❑
Heart Murmur:	❑	❑	Allergies to Penicillin:	❑	❑
Blood Pressure:	❑	❑	Allergies to Medications:	❑	❑
Artificial Joints:	❑	❑	Allergies to Latex:	❑	❑
Rheumatic Fever:	❑	❑	Anaemia or Blood Disorders:	❑	❑
Radiation Treatment:	❑	❑	Diabetes:	❑	❑
Excessive Bleeding:	❑	❑	Asthma:	❑	❑
Acid Reflux:	❑	❑	Hepatitis:	❑	❑
Sinus Trouble:	❑	❑	HIV:	❑	❑
Stroke:	❑	❑	Epilepsy:	❑	❑
Thyroid Problems:	❑	❑	Liver or Kidney Problems:	❑	❑
Osteoporosis:	❑	❑			
Cancer History:	❑	❑	Are you pregnant or breastfeeding?	❑	❑

Other_____

	Yes	No
Does your jaw 'click' or hurt?	❑	❑
Do you feel you grind your teeth?	❑	❑
Have you had orthodontic treatment?	❑	❑
Do you have a dental night guard?	❑	❑
Have you ever had periodontal (gum) treatment?	❑	❑
Have you ever had your bite adjusted?	❑	❑
Do you bite your lips or cheeks often?	❑	❑
Do you smoke?	❑	❑
Do you think you have bad breath?	❑	❑
Do your gums ever bleed when you clean your teeth?	❑	❑
Do your teeth hurt when you bite hard?	❑	❑
Does food ever get jammed between your teeth?	❑	❑
Are you interested in tooth whitening?	❑	❑

Is there anything else you would like us to know? Please list below:

_____

4. Consent

We would like to keep in touch about news and events at the practice, special offers and dental advice via our quarterly e-newsletter, Smile-mail.

I am happy to receive quarterly e-newsletters from the practice: Yes ☐ No ☐

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.

Due to Privacy & Confidentiality laws, we are prohibited from disclosing any information regarding your personal details and/or dental treatment unless you have personally signed a request form.

Full payment is required at the time of consultation. In the event that a bad debt is established the responsible party will be held accountable for the total account balance plus any fees incurred in collection of the debt.

We accept visa and mastercard, personal cheque, eftpos and cash. Third party payment plans are also available via GEM Visa.

A cancellation fee will apply if less than 48 hours notice is given.

Your Signature: _____ Date: _____/_____/_____