Kings Meadows Dental Care

NEW PATIENT FORM

Mr/Mrs/Ms/Miss/Master/Dr

Surname:……First Name:……
Preferred Name:……Date of Birth:……
Residential Address:……
……Post Code:……
Telephone: home/work:……Mobile:……
Email:……Reminder Method: SMS or Letter
Occupation:……

Do you have Dental Health Insurance: YES/NO if yes which fund?……
Are you a Veteran's Affair card Holder: YES/NO if yes, are you a GOLD or WHITE?……

If applicable**, is your Child eligible for the CHILD DENTAL BENEFIT SCHEME?** (CDBS): YES/NO
Medicare Card Number:……**Child's Reference Number**:……

MEDICAL HISTORY

Please tick if applicable and circle where necessary

Heat Attack/Murmur/Artificial Valves	Thyroid Disorder
Pacemaker/Angina/Cardiac Surgery	Ulcer / Hiatus Hernia
High / Low Blood Pressure	Epilepsy
Rheumatic Fever	High Cholesterol
Excessive Bleeding / Bruising /Blood Thinners	Anxiety / Panic Attacks / Depression
Anemia	Mental Illness
Arthritis	Artificial Joints / Joint Replacement
Osteoporosis	Do you need Antibiotic Cover / Allergies
Bisphosphonate Therapy / Prolia	Liver / Kidney Problems
Cancer Past /Present	Hepatitis A/B/C/D/E
Diabetes – Type 1 / Type 2	HIV / AIDS
Sinus Issues	Previous Anesthetic Problems
Asthma	Do you smoke
	Are you pregnant / Due Date

Other Medical Conditions: Please List:

Are you taking any medications**? Prescribed or over the counter**? Please list

Any allergies: Please list

Please turn over to complete other side

Family Doctor Name…… Phone……
Address……
Emergency Contact…… Phone……..
Relationship…… Phone……..

What is the main reason for attendance today ……..

……

Who can we thank for referring you to the practice? Friend / Family Member
Name……

Consent for Treatment

1. I hereby authorize the dentist or designated team to take x-rays, study models, photography and diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

2. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to perform proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payments for 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 with the Practice Manager.

5. All amounts not paid within our agreed payment terms are referred to our collection agency will be liable for all fees and costs and any legal fees included to collect debt outstanding.

6. I authorize that this data may be reviewed by team members of this practice.

Cancellation Policy

We realise your time is valuable, as is ours. That's why we offer an Appointment Reminder Service. If you are unable to attend your appointment, we require you to give us at least 48 hours' notice to allow other patients the chance to book in for treatment they may need. In the event that you cancel within 24 hours or fail to attend this appointment, we may charge a fee.

PATIENTS' SIGNATURE……DATE……
Checked by (Dentist)……Signature……
If you are under 18 years of age, person responsible for account
NAME……Relationship……
PHONE……Signature……