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 Email

Occupation: .....

Do you have **Dental Health Insurance**: YES/NO - if yes list fund?.....

Member Number .....Ref No.....

Are you a **Veteran's Affair** card Holder: YES/NO if yes, are you a GOLD or WHITE?.....

Member Number .....

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	Are you pregnant / Due Date
Do you smoke	

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

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Family Doctor Name……. **Phone**……

Address……

Emergency Contact…… **Phone**……..

Relationship……

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

……..

Who can we thank for referring you to the practice? Friend / Family Member / Website / Australia Post Letterbox Pamphlet.

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 prior to the appointment with the Practice Manager.
5. All accounts not paid within our agreed payment terms are referred to a collection agency and you will be liable for all fees and costs and any legal fees incurred to collect outstanding debt.
6. I authorize that team members of this practice may review this data.

Cancellation Policy

We realise your time is valuable, as is ours. That is 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, list the person responsible for account below.

NAME…….. Relationship ……

PHONE……. Signature ……