

**Personal Details** *(Please fill in all areas)*

Title: Mr /Mrs /Miss /Ms /Dr

First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Surname: \_\_\_\_\_

Occupation: \_\_\_\_\_

Street Address \_\_\_\_\_

Email: \_\_\_\_\_

Suburb: \_\_\_\_\_

Phone (M): \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone (H): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone (W): \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Exp: \_\_\_\_ / \_\_\_\_

**Private Health Fund? YES / NO** If yes, which one: **HBF BUPA MBP SMILE** or Other: \_\_\_\_\_

Doctor (GP): \_\_\_\_\_

Contact Number: \_\_\_\_\_

 Do you have a REGULAR dentist? **YES / NO** Name: \_\_\_\_\_ Suburb: \_\_\_\_\_

**How did you hear about us?**

 Walk By / Yellow Pages Book / Yellow Pages Online / Family / Friend / Google / Radio / Facebook / Instagram/ Whitecoat / Signage / BUPA / HBF / Medibank / LifeCare Staff / Other Practice Other  
 (Please Specify): \_\_\_\_\_

**Health History: Do you have now, or have you ever had, any of the following medical conditions?**
*(Please tick any you have or had)*

Artificial Joints	<input type="checkbox"/>	Avian Flu	<input type="checkbox"/>	Penicillin Allergy	<input type="checkbox"/>
Angina	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Codeine Allergy	<input type="checkbox"/>
Anorexia/Bulimia	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Heart Valve Replacement	<input type="checkbox"/>	Sulphur Allergy	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Iodine Allergy	<input type="checkbox"/>
Diabetes: Type 1 / Type 2	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	SARS	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Hepatitis A B C <i>(please circle)</i>	<input type="checkbox"/>	Smoking/Tobacco Use	<input type="checkbox"/>	Reflux	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Bisphosphonate Therapy	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	Heart Attack/Bypass/Pacemaker <i>(please circle)</i>	<input type="checkbox"/>		<input type="checkbox"/>

 Ladies, is it possible that you are pregnant? **YES / NO / MAYBE** If yes/maybe how far along? \_\_\_\_\_ Months

Do you have any other medical conditions or allergies? \_\_\_\_\_

 Are you currently taking any medication? **YES / NO** \_\_\_\_\_

**For us to better accommodate individual needs and wants, please answer the following questions.**

Do you have any questions about adult braces?	YES	NO
Have you ever had braces or a plate?	YES	NO
Are you happy with the colour of your teeth?	YES	NO
Do your gums bleed when you brush?	YES	NO
Are any of your teeth loose?	YES	NO
Do any of your teeth react to hot or cold?	YES	NO
Are you aware of grinding or clenching your teeth?	YES	NO
Do you have clicking or pain in your jaw joint?	YES	NO
Do you snore or suffer from sleep apnoea?	YES	NO
Have you had your wisdom teeth taken out?	YES	NO
Do you get occasional sore throats, tonsillitis or <b>bouts of bad breath?</b>	YES	NO

What is your reason for attending today?

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Is there anything you dislike about your teeth?

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When was your last dental appointment?

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How long has it been since you had dental x rays?

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By submitting your details you are consenting to receiving marketing emails from us. To opt out of this service please tick the box provided.

Would you like to learn more about our FREE Dentisure™ Insurance?  Y / N

### Terms and conditions for the supply of dental services:

1. All treatment will be discussed by the dentist with the patient or patient's guardian if 18 years or younger prior to the provision of the dental services.

2. Radiographs (x rays) may be required to ascertain treatment needs

3. Is this a Compensation Claim?  Yes/No  If **yes** indicate claim type with an **X** in the box:

Criminal Injuries Compensation  Motor Vehicle Compensation

Workers Compensation

3.1 I understand that in the event that my claim is rejected by the relevant authority I will be personally liable for the cost of the provision of the dental services.

3.2 If this is a Workers Compensation Claim, please complete the following details:

Employer: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

4. A cancellation fee of \$50.00 will apply to any appointment cancelled without at least 24 hours' notice.

5. Full payment of your account is required on the day of the treatment.

6. Unpaid accounts will be subject to interest at the rate of 7% p.a., calculated for the period the account is due until the date it is paid.

7. In the event that your account is referred to a debt collection agency and/or law firm, you will be liable for all costs incurred in the recovery of the debt.

8. LifeCare Dental Privacy Policy:

I have read and understood the LifeCare Dental Privacy Policy:  Yes  or

I have had the opportunity to read and have chosen not to read, the LifeCare Dental Privacy Policy  Yes

I consent to the LifeCare Dental Privacy Policy  Yes

Patient's Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_