Dental **O**n **V**ictoria, Patient Information Sheet

Please fill in this form carefully and thoroughly.

TITLE: (Please circle) **MR MRS MISS MS DR**

LAST NAME: _____ **FIRST NAME**: _____

DATE OF BIRTH: _____/_____/_____ **AGE**: _____

HOME ADDRESS: _____

SUBURB: _____ **P/CODE**:_____

HOME PHONE NUMBER: _____ **MOBILE NUMBER**_____

EMAIL ADDRESS: _____**OCCUPATION**: _____

WORK CONTACT NUMBER:_____

EMERGENCY CONTACT: _____ **PH NUMBER**: _____

NAME OF PERSON RESPONSIBLE FOR FEES: _____

DO YOU HAVE: PRIVATE HEALTH INSURANCE **Y / N** COMPANY: _____

HOW DID YOU FIND OUT ABOUT US? _____

MEDICAL QUESTIONS.

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?
(*PLEASE TICK WHERE APPROPRIATE*)

HIGH BLOOD PRESSURE	☐	**KIDNEY DISEASE**	☐	**RHEUMATIC FEVER**	☐
DIABETES	☐	**HEART AILMENT**	☐	**THYROID PROBLEMS**	☐
EPILEPSY / FITS / STROKE	☐	**HEPATITIS**	☐	**AIDS / HIV**	☐
ASTHMA	☐	**TUBERCULOSIS**	☐	**BONE DISORDERS / DISEASES**	☐
EXCESSIVE BLEEDING	☐	**BLOOD DISORDER**	☐	**SMOKER**	☐

FOR FEMALE PATIENTS ARE YOU PREGNANT, IF YES HOW MANY WEEKS:_____

HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESSES OR OPERATIONS? **Y / N**_____

HAVE YOU EVER HAD ANY PROBLEMS FOLLOWING DENTAL TREATMENT? **Y / N**

ARE YOU TAKING ANY DRUGS, MEDICATIONS OR TABLETS? **Y / N IF YES, PLEASE LIST:**_____

_____

DO YOU HAVE ANY ALLERGIES (DRUGS, MEDICINES, LATEX) **Y / N** _____

NAME & PHONE NUMBER OF MEDICAL DOCTOR: _____

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

I authorise my insurance benefits to be paid directly to the provider, and allow the provider to release any information required to participating insurance companies for the processing of my claims. I also understand that I am financially responsible for any outstanding balance.

I understand that I will be responsible for any debt collection fees that may result if I fail to finalise my account by the requested date.

Patient / Guardian signature (if patient under 18): _____Date: _____

Printed Name (Use Block Capitals): _____

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