Title: Mr/Mrs/Miss/Master/Ms/Dr/Other:_____ Gender: M / F

First Names: _____ Surname: _____

Date of Birth: _____ Occupation: _____

Home Address: _____ Suburb: _____

State: _____ Post Code_____ Home Phone: _____

Mobile Number: _____ Email:_____

Who can we thank for referring you? _____ Medicare number: _____

In case of emergency Contact: Name: _____ Phone: _____

Have you got Private Health Insurance with Dental Cover: Yes / No If so, which fund? _____

MEDICAL HISTORY

Your GP: Name: _____ Phone: _____

Please circle to indicate if you have had any of the following:

Heart Condition /Artificial Heart Valve /Pace Maker /Stroke

Asthma /COPD/ Diabetes High or Low Blood Pressure

Osteoporosis/ Osteoarthritis /Anaemia /Tuberculosis

Nervous Problems /Hepatitis A B C / Rheumatic Fever /Excessive Bleeding

Epilepsy /Thyroid Problems/ Kidney/ Liver Disease HIV/AIDS

Chemical dependency/ Cortisone treatment/Cancer /Radiotherapy / Chemotherapy

Have you visit your GP recently? Yes / No If yes why?_____

Do you have or have you had any disease, condition not listed previously? Yes/ No. If yes please specify_____

Please list any known ALLERGIES (latex, penicillin, anaesthetics, aspirin, iodine, codeine, etc.)

_____

Are you taking any MEDICINES? Yes /No. If Yes Specify:

_____

Are you Pregnant? Yes/No

Are you a Smoker? Yes/ No

DENTAL HISTORY

Reason for today's visit? _____

Date of last dental x-rays_____

Please circle to indicate if you have any of the following?

Bad breath/ Bleeding gums/ Blister of lips or mouth /Dry Mouth /Finger nail biting/ Grinding teeth Swollen or bleeding gums /Lip, cheek biting/ Loose teeth

Broken Fillings/ Mouth Breathing /Mouth pain/ Orthodontist treatment

Pain around the ear/ Periodontal Treatment /Sensitivity to: hot/ cold/sweet/on biting

Sores or growth in your mouth/ Headaches/ Neck pain

CONSENT OF SERVICES

1. I, _____, have answered all questions to the best of my knowledge, and agree to notify the dentist of any changes to my health or medication. Where essential to the provision of optimal care I give consent for authorised members of this practice to seek further health history information from the relevant health care provider. I understand that my health information may be disclosed to authorise personnel where necessary for the provision of optimum care.

2. I hereby authorise the dentist or designated staff to use all necessary diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

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

4. I will 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 financial arrangements has been agreed prior to treatment and signed by both parties.

5. For appointments that require more than half an hour's treatment a minimum deposit of $60 must be paid at time of booking. If appointments are cancelled with less than 24 hours' notice, the deposit may be retained and not refunded by Smile Ville at the discretion of dentist.

6. I understand that Smile Ville requires **a minimum of 48 hours**' notice if I need to reschedule my appointment. If I do not give 24 hours' notice of cancellation, a broken appointment fee may apply.

7. A consultation fee is to be paid upfront for my first appointment.

8. I consent to Smile Ville contact me for the following:

Promotions: Yes / No Newsletters: Yes / No Appointment reminders: Yes /No

Patient /Guardian / Carer Signature _____ Date_____