THE DENTAL STUDIO
STIRLING

Thank you for choosing The Dental Studio Stirling.

Please read and sign our practice policy and complete the **Patient Information Form** overleaf. Patients under 18 years of age require a parent or guardian's signature and consent.

I understand and agree to the following:

- ✓ All information requested is strictly confidential and relevant in providing my dental care. Some conditions, medications and recreational drugs may be responsible for or related to my dental problems. I will disclose all prescription and non-prescription drugs being taken.
- ✓ I will advise my dentist of any changes to my personal or medical details and agree to sign a medical history update form upon request.
- ✓ I will not be discriminated against for having an infectious medical condition.
- ✓ I, or my guardian, am responsible for full payment of my account after each treatment on the day. Payments can be made by cash, EFTPOS, Visa or Mastercard. (Private cheques only by prior approval).
- ✓ Overdue accounts will be subject to an account surcharge.
- ✓ If an account remains unpaid, I will be responsible for all collection, interest and administration fees associated with debt recovery.
- ✓ I am responsible for any unpaid balance refused by Veterans Affairs, Workers Compensation or any other Insurance Claim.
- ✓ Missed appointments or late cancellations without adequate notice (two working days) will be charged for.
- ✓ We provide HICAPS facilities for direct Health Insurance rebates should your fund qualify. The amount of rebate is a matter between yourself and your health fund. You should contact your Health Fund for accurate information regarding entitlements.

NAME …………………………………………………………….......... **SIGNATURE** ……………………...
(Or Guardian Name)

DATE ……………...………………………………

Prevention is the best medicine! Our dedicated team at **The Dental Studio Stirling** encourage optimal dental health through regular visits with our Hygiene department. The majority of our patients pre-book their preventive care appointments in advance to ensure their preferred day and time. All pre-booked visits are afforded a courtesy reminder 2 weeks prior to allow for rescheduling if required.

Thank you for your time and co-operation.

PATIENT INFORMATION FORM

(PLEASE ANSWER ALL QUESTIONS THOROUGHLY)

PERSONAL INFORMATION

❑ MR ❑ MRS ❑ MISS ❑ MS ❑ DR ❑ OTHER……………………

SURNAME……………………………………………………………………………………

FIRST NAME………………………………………PREF NAME…………………………

DATE OF BIRTH…………/…………/………………..

RESIDENTIAL ADDRESS

HOME ADDRESS…………………………………………………………………………

SUBURB……………………………………STATE……………POST CODE……………

POSTAL ADDRESS (if different from residential address)

POSTAL ADDRESS………………………………………………………………………

SUBURB……………………………………STATE……………POST CODE……………

CONTACT DETAILS (please tick)

HOME: ……………………………………………❑ PREFERRED………

WORK: ……………………………………………❑ PREFERRED………

MOBILE: …………………………………………❑ PREFERRED………

EMAIL: ……………………………………………………………………

OCCUPATION:………………………………………………………………

EMPLOYER:…………………………………………………………………

HEALTH FUND:……………………………………………………………

PERSON RESPONSIBLE FOR ACCOUNT

❑ SELF ❑ OTHER…………………………………………………

❑ GUARDIAN (name)………………………………………………

WE LIKE TO THANK OUR PATIENT'S WITH A SMALL GIFT FOR THEIR REFERRALS. PLEASE TELL US HOW YOU HEARD ABOUT US?

❑ REFERRAL (Name)…………………………………………………… ❑ OTHER (specify)……………………………………………

MEDICAL HISTORY (please tick only that which applies to you, even if a previous condition)

❑ HEART CONDITIONS (specify what)
……………………………………………………………

❑ HEPATITIS (specify which type and when)
……………………………………………………………

❑ JOINT REPLACEMENT SURGERY (specify)
……………………………………………………………

❑ RECREATIONAL DRUG USE (specify)
……………………………………………………………

❑ CANCER (specify type)…………………………………

❑ RADIATION OR CHEMO THERAPY (when)
……………………………………………………………

❑ DO YOU SMOKE (how many) ……………………

❑ AIDS or HIV POSITIVE…………………………

❑ NERVOUS SYSTEM DISORDER…………

❑ GASTRIC ULCER………………………………

❑ BLOOD PRESSURE (specify)………………

❑ DIABETES (specify type)……………………

❑ TUBERCULOSIS (TB)…………………………

❑ THYROID DISEASE……………………………

❑ JAUNDICE OR LIVER DISEASE……………

❑ RHEUMATIC FEVER……………………………

❑ CARDIAC PACEMAKER………………………

❑ ASTHMA…………………………………………

❑ EXCESSIVE BRUISING/BLEEDING………

❑ LOW BONE DENSITY……………………

❑ EPILEPSY……………………………………

❑ ANY KNOWN ALLERGIES (specify)
……………………………………………………
……………………………………………………

❑ OTHER MEDICAL CONDITION (specify)
……………………………………………………
……………………………………………………

❑ **NONE OF THESE**

FEMALES ONLY

❑ PREGNANT (due date)……………………

❑ BREAST FEEDING…………………………

IMPORTANT Do you currently take any blood thinners? (Warfarin, Aspirin etc) ……………………………………………………

MEDICATIONS Please list any prescription, herbal, remedial and recreational drugs being taken……………………………
……

DENTAL HISTORY

When was your last dental visit………………

When were x-rays last taken……………………

Do you clench or grind your teeth……………

Have you ever seen one of the following:

❑ Periodontist (gums)

❑ Endodontist (root canal)

❑ Oral Surgeon (surgical)

❑ Prosthodontist (crowns/dentures)

❑ Other…………………………………

REASON FOR VISIT (please tick)

❑ Routine check up

❑ Teeth cleaning

❑ Pain relief

❑ Wisdom teeth

❑ Whitening/cosmetics

❑ Straightening teeth

❑ Implants/dentures

❑ Lost filling or crown

❑ Second opinion or quote

SYMPTOMS (please tick)

❑ Bleeding gums

❑ Sensitive to cold/hot

❑ Teeth sensitive to sweet

❑ Tooth sore to bite on

❑ Jaw joint problems

❑ Food getting stuck

❑ Floss catches

❑ Other……………………………
……………………………………

SIGN…………………………………………… **DATE**……………………… **GUARDIAN'S NAME**……………………………………

OFFICE USE ONLY Please date and initial below **(ONCE ONLY).** If your medical history needs amending, make note of changes on amendment form.

DATE……/………/…………CHANGES? YES / NO INITIAL………… DATE……/………/…………CHANGES? YES / NO INITIAL…………