Welcome to First Dental Studio

Title: _____Last Name: _____First Names: _____

Street Address: _____

Suburb _____ Post Code: _____

Work Address: _____ Post Code: _____

Preferred Mailing Address: _____ Post Code: _____

Telephone: (Work) _____ (Home) _____ (Mobile) _____

Email: _____

Date of Birth: _____Occupation: _____

Do you have Private Health Insurance? (Which Fund?) _____

Your health fund ID no: 00 / 01 / 02 / 03 / 04 / 05 (Please circle)

Which is the best contact method to contact you? Home Work Mobile Email

How did you find out about our Practice? _____

The greatest compliment we receive is when one of our patients refers a friend or family member to see us. If you were referred, please tell us whom to thank.

The following questions are of a medical nature and will ensure that we are able to provide the very best possible care for you. Answers will be kept in strict confidence according to the Australian Dental Association Privacy Statement.

Are you under the care of a doctor? If so, for what reason? _____

Are you taking any medications at present? If so, what is it? _____

Do you have any known allergies? (Eg to medications, latex) _____

For females, are you pregnant? If so, how many months? _____

Are you a smoker? If so, how many per day? _____

Is there any reason for you to suspect that you are at risk of having AIDS or any other disease related to AIDS? _____

Do you require antibiotic cover before dental treatment (heart condition)? _____

Have you ever had an adverse reaction to any procedure performed by a dentist?

Please describe: _____

Please turn over the page

Have you ever had any of the following conditions? (Please tick the appropriate box)

Condition	Yes	No	Condition	Yes	No
High or Low Blood Pressure			Diabetes		
Heart Disorder or Heart Complaint of any Kind			Asthma, Bronchitis or other Lung Condition		
Chest Pain			Epilepsy		
Cardiac Pacemaker			Hepatitis or other Liver Condition		
Prosthetic Heart Valves or Joints			Kidney Disease		
Rheumatic Fever			Stomach or Digestive Condition		
Anaemia or Other Blood Condition			Organ or Marrow Transplant or Blood Transfusion		
Excessive or Prolonged Bleeding			Cancer or Tumour		

Do you have any other illness or disability? Please specify: _____

Dental History

1. When was your last dental check-up? _____Months
2. Are you having any specific problems with your teeth, gums or mouth? Yes No
3. Do you have sensitivity to hot, cold or sweets? Yes No
4. Do you have discomfort when chewing? Yes No
5. Do your gums bleed after brushing? Yes No
6. Have you noticed your gum receding? Yes No
7. Do you frequently have food caught between your teeth? Yes No
8. Do you clench or grind your teeth? Yes No
9. Do you ever have frequent headaches, stiffness or soreness in your jaws or your neck? Yes No
10. Do you brush your teeth morning and night? Yes No
11. Do you regularly floss your teeth? Yes No
12. Are you dissatisfied with the appearance or colour of your teeth? Yes No
13. In general, do dental treatments cause you concern or apprehension? Yes No

I hereby state that I have understood and answered the questions to the best of my knowledge.

Patient's Signature: _____ Date: _____

Thank you for choosing First Dental Studio for your dental care. We are committed to your treatment being of the highest quality. The following is a statement of our Financial and Privacy Policies which we require you to read, understand, and sign prior to any treatment.

Financial Policy

FULL PAYMENT IS DUE AT THE TIME OF TREATMENT

WE ACCEPT HICAPS, CASH, EFTPOS, CREDIT CARDS

Our practice is committed to providing you with the best treatment - we charge what is usual and customary for the service. Our dentists will inform you of the fees before your treatment begins. It is your responsibility to discuss any financial concerns you have before you start your treatment.

All appointments are confirmed one (1) business day prior.

Your private health fund claim is processed at the time of your appointment, and the remainder of the fees will become your full immediate responsibility.

Privacy Policy

The information contained in this questionnaire and during appointments forms a confidential and private document between yourself and the practice. It is understood that the information collected is of a sensitive nature, but it is important for your dental treatment and collected with your consent. This information will only be discussed with the patient or the patient's guardian. First Dental Studio will protect the information from misuse and loss. Please ask our staff if you would like to see the extended version of the Privacy Policy.

Consent to Proceed

Thank you for understanding our Financial and Privacy Policies. Please let us know if you have any questions or concerns.

I have read the Financial and Privacy Policies above. I understand and agree to the terms above.

Name of Patient _____

Signature of Patient or Guardian _____

Date _____