Welcome to our practice

We look forward to giving you the best possible service and treatment so that you can enjoy the benefits of healthy teeth and a beautiful smile.

Patient Details

Title: Mr / Mrs/ Ms/ Dr / Other _____ Surname:_____ Given Name:_____
Date of Birth: _____/_____/_____
Residential Address: _____
Contact: (Home) _____Mobile: _____
Contact (Work) _____Email: _____
Occupation: _____Company: _____
Emergency Contact: Name _____PH: _____ Relation: _____
Dental Fund (if any): _____If covered by a health fund for dental treatment we may be able to process your claim 'on-the-spot' via the HICAPS system. You will be required to pay the balance as normal.
How will you be paying your account? CASH ☐ C/CARD ☐ EFTPOS ☐ HICAPS ☐

When was your last dental visit? _____How often do you visit the dentist? _____
What did you like the most about your last dentist? _____
What is your main concern today? _____
For dental treatment do you prefer injections? Yes / No / Sometimes
Have you ever had a problem with a previous injection? _____

How did you hear about us? (Please tick one)

Referred by a Family/ Friend ☐ Google ☐ Six Twelve Website ☐ Facebook/Instagram ☐ Other ☐
If referred by a family member or a friend, please specify who _____
Would you like to receive your appointment reminders and 6 monthly check up reminders via:
SMS ☐ Home Telephone ☐ Mobile ☐ Email ☐ Letter in the mail

Medical History Please indicate below**:**

- ☐ Abnormal Bleeding
- ☐ Heart Condition/ Disorder
- ☐ Rheumatic fever
- ☐ Hepatitis A B C
- ☐ Infectious Disease (e.g. HIV/AIDS)
- ☐ Depression
- ☐ Drug or alcohol abuse
- ☐ Radiotherapy/Chemotherapy
- ☐ Stroke
- ☐ Epilepsy
- ☐ Joint Replacement
- ☐ Asthma/ Lung condition
- ☐ Blood Pressure High / Low (Please circle)
- ☐ Nerve Disorders
- ☐ Bisphosphonates – Bone Disease
- ☐ Oral Cancer
- ☐ Pregnant? Due Date: _____
- ☐ Diabetes: Type 1 Type 2 (Please circle)
- ☐ Liver/ Kidney Diseases
- ☐ Sleep apnoea
- ☐ Other Serious Illnesses_____

Are you taking Medication? If yes, please specify_____
Do you have any known allergies? If yes, please specify: Penicillin ☐ Aspirin ☐ Iodine ☐ Latex ☐ Other:_____
Note: All information collected is solely for the purpose of dental treatment and will be treated with complete professional confidentiality. No information will be disclosed to third parties without consent.

Declaration

I hereby declare that true and accurate information has been given to the best of my knowledge.

Patient's Signature: _____ Date: _____