robina town DENTAL

Dedicated to beautiful smiles.

The team at Robina Town Dental would like to welcome you to their practice.

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information includes not only basic details, but it is also necessary to obtain from you information regarding your general health and past medical and surgical events. We understand that some of this information is of a personal nature, and not information you would want disclosed to others. We value the need to safeguard this information, and abide by the principles laid down in privacy legislation and the guidelines provided by the Australian Dental Association (available at your request).

PERSONAL DETAILS

Title:..... **First Name:**..... **Surname:** ..... **Date of Birth:** .....

Address: ..... **Postcode:** .....

Phone: Home: ..... **Work:** ..... **Mobile:** .....

Email .....

Occupation: .....

Who recommended you to us? .....

If under 18, please state mother and father's or guardian's name: .....

Robina Town Dental does not issue accounts and requires payment for each appointment, in full, at the completion of the visit. In some circumstances the team will require a deposit prior to booking an appointment (eg. orthodontics). Any disputes with a third party (e.g. health insurance) are to be dealt with between yourself and the third party as privacy legislation prevents us from contacting them on your behalf. In the event of non-payment of accounts, any third party and solicitors fees incurred are payable, in full, by the patient.

Do you agree to Robina Town Dental's financial policy? **Yes / No**

COMMUNICATIONS

We love to keep in touch with our patients and send out communications both digital and physical to keep you updated on our practice and dentistry as a whole.

☐ Please tick if you would like to be included as part of our communication and email database.

DENTISURE™ Our Patient Loyalty Bonus

At Robina Town Dental, we have partnered with Dental Care Network to offer Dentisure™, as a 'Patient Loyalty Bonus' to all eligible patients. This includes FREE coverage against dental accidents. If you would like to sign up for Dentisure™ for free and with no ongoing costs ever, simply inform one of our team members will assist you.

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? **Yes / No**

If yes, for what? .....

Physician's Name: ..... **Phone:** .....

Surgery Name: .....

Are you taking any medication, drugs or pills now? **Yes / No**

If yes, please list name and dosage: .....

Are you aware of having an allergic (or adverse) reaction to any medication or substance? **Yes / No**

If yes, please list: .....

Have you been a patient in the hospital during the past five years?? **Yes / No**

Indicate which of the following you have had, or have at present:

- ☐ Heart (Surgery, disease, attack)
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Cortisone Medicine
- ☐ Excessive Bleeding
- ☐ Blood Thinning Medication
- ☐ Stroke
- ☐ Stomache Ulcers
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Latex Sensitivity
- ☐ Sinus Troubles
- ☐ Radiation Therapy
- ☐ Stomach/Digestive Condition
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Haemophilia
- ☐ Anemia/Leukemia/Blood Disorder
- ☐ Liver Disease
- ☐ Kidney Trouble
- ☐ Neurological Disorders
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous/Anxious
- ☐ Artificial Joints (hip, knee, etc)
- ☐ Tumours
- ☐ Reflux
- ☐ Bruise Easily
- ☐ Cold Sores/Fever Blisters

Do you have or have you had any disease, condition or problem not listed? **Yes / No**

If yes, please list: .....

Do you require Antiobiotic Coverage prior to dental treatment? **Yes / No**

Are you or have you ever been a smoker? **Yes / No**

Women - are you: **Pregnant?** **Yes / No**

If yes, **months:** ..... **No:** .....

Nursing? **Yes / No**

CONFIRMATION

I give my immediate family permission to act as an agent on my behalf: **Yes / No**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

....

Patient/Guardian Signature **Date**