

## **CONTACT DETAILS**

ARE YOU COVERED BY DENTAL INSURANCE : YES ☐ NO ☐ IF YES, FUND NAME :	TITLE: DR  MR  MRS  MS  MISS  MST	SURNAME:
HOME ADDRESS:  SUBURB: POSTCODE:  MAILING ADDRESS (IF DIFFERENT TO ABOVE):  HOME PHONE: WORK PHONE:  MOBILE PHONE: EMAIL:  EMERGENCY CONTACT NAME: PHONE:  DOCTOR'S NAME: PHONE:  HOW DID YOU FIND OUT ABOUT OUR CLINIC? INTERNET/WEBSITE WALK/DRIVE BY ADVERTISEMENT DENTAL HISTORY  DENTAL HISTORY  DO YOU HAVE ANY OF THE FOLLOWING CONCERNS? DISCOLOURED TEETH SERSITIVITY  MORN/BROKEN TEETH FREQUENT HEADACHES DENTURE ISSUES GUM PROBLEMS NORING CONCERNS POSITIVITY  DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?  HIGH BLOOD PRESSURE HEART VALVE SURGERY DIABETES FILEPSY RHEUMATIC FEVER AIGHSHIP CANCER TREATMENT BLIBSHIP SLEEP APNEA  ANY OTHER SERIOUS HEALTH ISSUES OR OPERATIONS:  CURRENT MEDICATIONS:  ANY KNOWN ALLERGIES: DO YOU SMOKEP: YES NO LACCOUNT DETAILS  PERSON RESPONSIBLE FOR FEES: MYSELF OTHER NAME:  MEDICARE CARD NO: LINE NO. EXPIRITY DATE (MM/YYYY): ./.  ARE YOU COVERED BY DENTAL INSURANCE: YES NO IF FYES, FUND NAME:	GIVEN NAME(S):	PREFERRED NAME:
SUBURB: POSTCODE:	DATE OF BIRTH: /	
MAILING ADDRESS (IF DIFFERENT TO ABOVE):  HOME PHONE:  MOBILE PHONE:  EMAIL:  EMERGENCY CONTACT NAME:  PHONE:  HOW DID YOU FIND OUT ABOUT OUR CLINIC? INTERNET/WEBSITE   WALK/DRIVE BY   ADVERTISEMENT    FRIEND/FAMILY   NAME:  DENTAL HISTORY  DO YOU HAVE ANY OF THE FOLLOWING CONCERNS? DISCOLOURED TEETH   SENSITIVITY   SENSIT	HOME ADDRESS:	
HOME PHONE:	SUBURB:	POSTCODE:
MOBILE PHONE:	MAILING ADDRESS (IF DIFFERENT TO ABOVE):	
EMERGENCY CONTACT NAME: PHONE:  DOCTOR'S NAME: PHONE:  HOW DID YOU FIND OUT ABOUT OUR CLINIC? INTERNET/WEBSITE   WALK/DRIVE BY   ADVERTISEMENT    FRIEND/FAMILY   NAME: OTHER   HOW:  DENTAL HISTORY  DO YOU HAVE ANY OF THE FOLLOWING CONCERNS? DISCOLOURED TEETH   SENSITIVITY   MISSING TEETH   PAIN IN JAW   DENTURE ISSUES   GUM PROBLEMS    SNORING   CROOKED TEETH   BENJESTORY  DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?  HIGH BLOOD PRESSURE   HEART VALVE SURGERY   EXCESSIVE BLEEDING   HEPATITIS   HEPATITIS   DIABETES   EPILEPSY   GASTRIC REFLUX   CANCER TREATMENT   JOINT REPLACEMENT   KIDNEY DISEASE   BISPHOSPHONATE TREATMENT    ANY OTHER SERIOUS HEALTH ISSUES OR OPERATIONS:  CURRENT MEDICATIONS:  ANY KNOWN ALLERGIES: DO YOU SMOKE?: YES   NO   LADIES, ARE YOU PREGNANT: YES   NO    ACCOUNT DETAILS  PERSON RESPONSIBLE FOR FEES: MYSELF   OTHER   NAME:    MEDICARE CARD NO: LINE NO: EXPIRY DATE (MM/YYYY): /  LINE NO: EXPIRY DATE (MM/YYYY): /	HOME PHONE :	WORK PHONE:
DOCTOR'S NAME: PHONE:  HOW DID YOU FIND OUT ABOUT OUR CLINIC? INTERNET/WEBSITE  WALK/DRIVE BY ADVERTISEMENT   FRIEND/FAMILY NAME: OTHER   HOW:    DENTAL HISTORY	MOBILE PHONE:	EMAIL:
HOW DID YOU FIND OUT ABOUT OUR CLINIC? INTERNET/WEBSITE   WALK/DRIVE BY   ADVERTISEMENT    FRIEND/FAMILY   NAME:	EMERGENCY CONTACT NAME:	PHONE:
DENTAL HISTORY  DO YOU HAVE ANY OF THE FOLLOWING CONCERNS? DISCOLOURED TEETH   SENSITIVITY   MISSING TEETH   PAIN IN JAW   MORN/BROKEN TEETH   FREQUENT HEADACHES   DENTURE ISSUES   GUM PROBLEMS   SNORING   CROOKED TEETH   DENTURE ISSUES   GUM PROBLEMS   DENTURE ISSUES   GUM PROBLEMS   DENTINE ISSUES   GUM PROBLEMS   DENTINE ISSUES   GUM PROBLEMS   DENTINE ISSUES   GUM PROBLEMS   DENTINE ISSUES   DENTINE ISSUES   GUM PROBLEMS   DENTINE ISSUES   GUM PROBLEMS   DENTINE ISSUES   DENTINE ISSUES OR OPERATIONS :  MEDICAL HISTORY  MEDICAL HISTORY  DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?  HIGH BLOOD PRESSURE   HEART VALVE SURGERY   DIABETES   EPILEPSY   FILEPSY   DIABETES   FILEPSY   DIABETES   D	DOCTOR'S NAME:	PHONE:
DENTAL HISTORY  DO YOU HAVE ANY OF THE FOLLOWING CONCERNS? DISCOLOURED TEETH	HOW DID YOU FIND OUT ABOUT OUR CLINIC? INTERNET/WEBSITE ☐ WALK/DRIVE BY ☐ ADVERTISEMENT ☐	
DO YOU HAVE ANY OF THE FOLLOWING CONCERNS? DISCOLOURED TEETH	FRIEND/FAMILY NAME:	OTHER HOW:
DISCOLOURED TEETH	DENTAL HISTORY	
MEDICAL HISTORY  DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?  HIGH BLOOD PRESSURE	DISCOLOURED TEETH SENSITIVITY SUBJECT SHORING SENSITIVITY SENSITIV	DENTURE ISSUES GUM PROBLEMS
HIGH BLOOD PRESSURE		
RHEUMATIC FEVER GASTRIC REFLUX CANCER TREATMENT DISABILITY CANCER TREATMENT DISABILITY SLEEP APNEA DISABILITY SLEE	DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?	
CURRENT MEDICATIONS:  ANY KNOWN ALLERGIES:  DO YOU SMOKE?: YES NO LADIES, ARE YOU PREGNANT: YES NO   ACCOUNT DETAILS  PERSON RESPONSIBLE FOR FEES: MYSELF OTHER NAME:  MEDICARE CARD NO: LINE NO: EXPIRY DATE (MM/YYYY): //  ARE YOU COVERED BY DENTAL INSURANCE: YES NO IF YES, FUND NAME:	RHEUMATIC FEVER AIDS/HIV GASTRIC REFLUX CANCER TREATMENT	DIABETES EPILEPSY DISEASE DISEASE
ANY KNOWN ALLERGIES:  DO YOU SMOKE?: YES NO LADIES, ARE YOU PREGNANT: YES NO ACCOUNT DETAILS  PERSON RESPONSIBLE FOR FEES: MYSELF OTHER NAME:  MEDICARE CARD NO: LINE NO: EXPIRY DATE (MM/YYYY): // ARE YOU COVERED BY DENTAL INSURANCE: YES NO IF YES, FUND NAME:	ANY OTHER SERIOUS HEALTH ISSUES OR OPERATIONS:	
DO YOU SMOKE?: YES NO LADIES, ARE YOU PREGNANT: YES NO ACCOUNT DETAILS  PERSON RESPONSIBLE FOR FEES: MYSELF OTHER NAME:  MEDICARE CARD NO: LINE NO: EXPIRY DATE (MM/YYYY): /.  ARE YOU COVERED BY DENTAL INSURANCE: YES NO IF YES, FUND NAME:	CURRENT MEDICATIONS:	
ACCOUNT DETAILS  PERSON RESPONSIBLE FOR FEES: MYSELF  OTHER  NAME:  MEDICARE CARD NO: LINE NO: EXPIRY DATE (MM/YYYY): ./.  ARE YOU COVERED BY DENTAL INSURANCE: YES NO IF YES, FUND NAME:		
PERSON RESPONSIBLE FOR FEES: MYSELF  OTHER  NAME:  MEDICARE CARD NO: LINE NO: EXPIRY DATE (MM/YYYY): ./.  ARE YOU COVERED BY DENTAL INSURANCE: YES  NO  IF YES, FUND NAME:		
MEDICARE CARD NO: LINE NO: EXPIRY DATE (MM/YYYY):/  ARE YOU COVERED BY DENTAL INSURANCE: YES  NO  IF YES, FUND NAME:		
ARE YOU COVERED BY DENTAL INSURANCE : YES ☐ NO ☐ IF YES, FUND NAME :	PERSON RESPONSIBLE FOR FEES: MYSELF ☐ OTHER ☐ NAME:	
	MEDICARE CARD NO:	LINE NO: EXPIRY DATE (MM/YYYY): /
CARD NO:	ARE YOU COVERED BY DENTAL INSURANCE : YES NO IF YES, FUND NAME :	
I UNDERSTAND THAT PAYMENT IS REQUIRED ON DAY OF TREATMENT UNLESS OTHERWISE ARRANGED.	I I INDERSTAND THAT DAYMENT IS DECLUDED ON DAY	CARD NO:

I UNDERSTAND THAT MAYMENT IS REQUIRED ON DAY OF TREATMENT UNLESS OTHERWISE ARRANGED.

I UNDERSTAND THAT MORE THAN 24HRS IS REQUIRED FOR RESCHEDULING OF APPOINTMENTS.

IN THE EVENT WHERE I HAVE AN OVERDUE ACCOUNT WHICH IS REFERRED TO A COLLECTION AGENCY AND/OR LAW FIRM, I UNDERSTAND I WILL BE LIABLE FOR ALL COSTS WHICH WOULD BE INCURRED AS IF THE DEBT IS COLELCTED IN FULL, INCLUDING LEGAL DEMAND COSTS.