oceanview dental
dentistry for generations

PATIENT DETAILS FORM

To be sure we have the most current contact information for you, please complete the following questionnaire.

PATIENT DETIALS

Surname: _____ Give Names: _____
Preferred Name: _____ Title (Dr, Mrs, Ms, Mr, Master etc.): _____
Date of Birth: / / Occupation: _____
Address: _____ Suburb: _____ Postcode: _____
Home Phone: _____ Work Phone: _____
Mobile Phone: _____ Email: _____

☐ Tick if you do not want to receive our newsletter

Do you have private health insurance? (Please circle) YES / NO
Name of Fund: _____
Family Doctor: _____ Phone: _____

If the Patient is under 18 years of age:

Parent Guardian's Name: _____ Contact Number: _____
Parent Guardian's Name: _____ Contact Number: _____

PERSON RESPONSIBLE FOR ACCOUNT

☐Self – details same as above (Please tick box)

If the account holder is different to the above please fill out the details below:
Full Name: _____ Contact Number: _____
Address: _____ Suburb: _____ Postcode: _____
Relationship to Patient (Please tick): ☐Parent / Care Giver ☐other, please specify: _____

EMERGENCY CONTACT

(if different to account holder):
Full Name: _____ Contact Number: _____

HOW DID YOU HEAR ABOUT US?

☐ Walk In
☐ Patient Referral
Who referred you?
_____
☐ Staff Referral
☐ Local Directories
☐ Our Website
☐ Facebook
☐ Flyer
☐ Advertisement
☐ Street Sign
☐ Ocean View College
☐ Local in the Area
☐ Google Search
☐ Another Dentist
☐ Local Business
☐ Dental Specialist
☐ Other, please specify: _____
☐ Football Club
☐ Newspaper
☐ TLC Pharmacy
☐ Health Fund
☐ Yellow Pages

Names of other family members attending this practice: _____

_____

DENTAL HISTORY

What is the reason for your visit today? _____
When was your last visit to the dentist? _____
Do your gums bleed (Please circle)? YES / NO
Have you ever been treated for gum disease/periodontitis? _____
Do you use an electric tooth brush? (Please circle) YES / NO

MEDICAL HISTORY

Are you currently pregnant (Please Circle)? YES / NO How many weeks? Est Due Date:

Do you smoke? (Please Circle) YES / NO would you like information on quitting smoking? YES / NO

Do you have any of the medical issues below? Please tick

Are you allergic to Latex? (Please circle) YES / NO

☐ Asthma	☐ Bleeding Problems	☐ Diabetes
☐ Depression	☐ Liver Disease	☐ Kidney Disease
☐ Epilepsy	☐ Fainting	☐ HIV/AIDS
☐ Cancer	☐ Osteoporosis	☐ Heart Disease
☐ Stroke	☐ Blood Pressure high/low	

☐ **OTHER, please specify:**

_____

If you are taking any medication or drugs, please provide details below:_____

_____

Are you allergic to Penicillin, Anaesthetic or others? Please list:_____

Are there any other conditions this practice should be aware of?_____

APPOINTMENT CANCELLATION & FAILING TO ATTEND POLICY

When you make an appointment at Oceanview Dental we make a commitment to reserve clinical time just for you.

Appointment Reminders

We consider all appointments 100% confirmed at the time of booking and operate several courtesy reminder services via SMS, telephone or email prior to all appointments.

Cancellation and Fail to Attend Fees

Patients that cancel appointments with less than 24hrs notice, or simply fail to attend an appointment, greatly impact our ability to provide affordable fees and high levels of quality service that we strive to deliver here at Oceanview Dental.

We understand that situations may arise that would make it impossible to give 24hrs notice, so each instance will be given consideration based upon its merits and previous appointment history.

We reserve the right to charge a non-refundable cancellation fee of $50 for any appointment that is cancelled with less than 24hrs notice without good reason, or if a patient fails to attend. Cancellations or fail to attend fees need to be cleared before any further appointments will be booked or treatment undertaken.

Patients that develop a history of late notice cancellations and/or failing to attend appointments may no longer be able to make an appointment at Oceanview Dental without approval of the Practice Manager. They may also be required to pay all appointments fees in advance as a condition of making future appointments.

We reserve the right to forfeit any deposits paid for appointments that are cancelled with less than 24hrs notice, or if a patient fails to attend.

Please understand that we consider this a last resort and at Oceanview Dental we have a real concern for the quality of service that we are to provide to you and to our other valued patients.

I acknowledge the Appointment Cancellation and Failing to Attend Policy as outlined above:

Signature: _____ Date_____/_____/_____