

PATIENT DETAILS FORM

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

PATIENT DETAILS

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: _____

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?

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

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 Ocean View 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 48hrs notice, or simply fail to attend an appointment, greatly impact our ability to provide affordable fees and high levels of quality service that we deliver here at Ocean View Dental and also prevent patients seeking emergency care to access services in a timely manner.

We reserve the right to charge a non-refundable cancellation fee of \$50 for any appointment that is cancelled with less than 48hrs notice, 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 Ocean View Dental without approval of the Director. They may also be required to pay all appointments fees in advance as a condition of making future appointments.

Booking Fees

We reserve the right to forfeit any booking fees paid for appointments that are cancelled with less than 48hrs notice, or if a patient fails to attend.

Please understand that we consider this a last resort and at Ocean View 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 ____/____/____