

## 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"/> Advertisement	<input type="checkbox"/> Local Business	<input type="checkbox"/> Health Fund
<input type="checkbox"/> Staff Referral	<input type="checkbox"/> Street Sign	<input type="checkbox"/> Dental Specialist	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Local Directories	<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      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**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Depression	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Blood Pressure high/low	

**OTHER, please specify:**

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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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_