serene
DENTAL

MEDICAL & DENTAL HISTORY FORM

All information completed on this form will remain strictly confidential. Please complete in **CAPITAL LETTERS.**

Surname		Given Names	Dr/Mr/Mrs/Ms/Miss
Date of Birth		Occupation	
Best Daytime contact Number (8am-5pm) Phone (Mobile)	☐ ☐	Home Address Postcode	
Email address (for annual, 6-monthly reminders)			
Emergency contact (please provide name and phone number):			

ALL APPOINTMENTS WILL BE CONFIRMED VIA SMS UNLESS SPECIFIED OTHERWISE

What is your preferred method for appointment IF NOT SMS? ☐ Email ☐ Phone call

Referral Information

☐ Internet/Website ☐ Signage ☐Other ☐ Newspaper ☐ Family / Friend: ___________________________

☐ Patient (please provide name so that we can thank them) ___________________

DENTAL HISTORY

Are you experiencing any of the following dental problems? (please tick as many that applies)

☐ Sensitivity to hot or cold
☐ Staining of your teeth
☐ Bleeding gums
☐Head/neck ache
☐ Food trapping between your teeth
☐ Discoloured fillings
☐ Bad breath
☐ Grinding or clenching of your teeth
☐ Clicking/pain in the jaw joints
☐ Roughness of existing fillings
☐ Sensitivity when eating

Are you concerned with: (please tick as many as it applies)

☐ Existing crowns, bridges or dentures
☐ Tooth clean techniques (e.g. Brushing / Flossing)
☐ Crooked teeth
☐ Previous dental treatment
☐ Ability to eat
☐ Your smile
☐ Missing teeth
☐ Gaps between your teeth
☐ Discolouration of your teeth
☐ Silver fillings

What is the main purpose of your visit today?

____

How long since your last dental visit? ____

Please Turn Over

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

PLEASE TURN THIS PAGE OVER TO CONTINUE

Have you ever had or require the following for dental treatment?

☐ Gas (Nitrous oxide-laughing gas) ☐ Intravenous sedation ☐ General Anaesthesia

MEDICAL HISTORY

Name of your GP (if known):		Your Doctor's Phone No.	
Your Doctor's address:			

Have you ever had any of the following? Please tick as many that apply:

❑ Anaemia	❑ Fainting	❑ Pacemaker
❑ Artificial joints	❑ Glaucoma	❑ Radiation Therapy
❑ Asthma	❑ Heart Disease	❑ Respiratory problems
❑ Blood Disease	❑ Heart Murmur	❑ Rheumatic fever
❑ Cancer	❑ Hepatitis A, B, C	❑ Sinus problems
❑ Dizziness	❑ Kidney Disease	❑ Stroke
❑ Epilepsy	❑ Liver Disease	❑ Tuberculosis
❑ Excessive Bleeding	❑ HIV/ AIDS	❑ Tumours
❑ Diabetes	❑ Osteoporosis	❑ Psychological Disorders
If female are you currently pregnant? **If yes, how many months?**	YES / NO months____________	

Have you had any serious illnesses in the last 2 years? If yes, please provide more information.	
Are you currently taking any medications or tablets regularly? If yes, please provide more information.	
Are you taking or have you taken any Bisphosphonate Drugs?	
Do you have any allergies to Penicillin or other drugs? If yes, please provide more information.	
Do you suffer from sleep apnoea / snoring?	
Is your blood pressure normal, high or low?	
Do you smoke? If so how many per day?	

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- From time to time we will send you newsletters and special offers, please let us know if you do not want to receive these.
- I understand that the practice requires as minimum 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 could be incurred if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment.

x____ ________________________________

Patient Signature **Date of signature**

PLEASE TURN THIS PAGE OVER TO CONTINUE

Cancellation and Failure to Attend Policy

We understand that things come up, meaning you may have to reschedule your dental appointment. However, last minute cancellations, failed attendance or late arrival disrupts our staff and their ability to offer the best service to other patients.
We plan each day carefully around our patients to allow for sufficient time to attend to each patient's needs and any last minute changes can greatly affect our day.
With this in mind, the following Cancellation and Failure to Attend Policy applies:

- Cancellations to appointments with *less than 24 hours'* notice will:
  - ***Initial cancellation***: Warning
  - ***Subsequent cancellations: $100 cancellation fee*** will be applied. These are non-refundable and cannot be claimed on health insurance.
- Cancellations or changes to appointments with *less than 48 hours'* notice will require a $100 deposit to secure a further appointment.
- Serene Dental reserves the right to kindly request that patients who continually cancel appointments with short notice, fail to attend, or arrive late, arrange to continue their dental treatment elsewhere.

Our aim is to provide the best quality dental care for all our patients, and we can only continue to do this by keeping to our appointment schedule. We are sure that you understand this and will do your best to help us help you.

I ___________________________________ confirm that I have read and understand the above policy.

Signed: _________________________________ Date: _________________________

PLEASE TURN THIS PAGE OVER TO CONTINUE