fab dental

1 Hayward St
Paddington Qld 4064
Phone: 3367 1999
Email: info@fabdental.com

Title:_____ **First Name**:_____ **Surname**:_____ DOB:_____

Dr/Mr/Master/Mrs/Miss/Ms

Home Address:_____

_____ **Postcode**: _____

Phone No. Home: _____ **Mobile:** _____ **Occupation**: _____

Email address: _____ **Health Fund:**_____

Emergency contact:

Name: _____ **Their Phone No**.: _____

Who can we thank for referring you to our practice: _____

Please circle the best method that we can contact you: **SMS** **EMAIL** **MOBILE** **HOME** **WORK**

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this (please tick box)	❑

Please tick Yes or No	Yes	No	Please tick Yes or No	Yes	No
Rheumatic fever			Osteoporosis or low bone density		
Heart condition/cardiac surgery/pacemaker ***(please circle)***			Arthritis		
Heart valve replacement			Cancer		
High or Low Blood Pressure ***(please circle)***			Radiation therapy/ Chemotherapy		
Blood Disorders			Transplanted organ/bone marrow/stem cells		
Excessive bruising or bleeding			Joint replacement surgery		
Hepatitis – A, B or C ***(Please circle)***			Thyroid Disease		
Jaundice or liver disease			Tuberculosis (TB)		
HIV or AIDS			Anxiety/depression		
Kidney/renal disease			Snoring/sleep apnoea		
Asthma/bronchitis/lung condition ***(please circle)***			Jaw, neck or shoulder injury or pain		
Diabetes			Severe headaches		
Epilepsy/Seizures			Any illness not listed above		

Please tick	Yes	No	List Medications
Do you normally require antibiotic cover before dental treatment			
Do you smoke			
Are you Pregnant (females only)			
Are you being treated by a doctor at present?			
Are you taking any prescription or other medications at present?			
Have you been hospitalised in the last 12 month?			
Do you have dental pain or dental problem at present			
Do you brush and floss daily			
Do you experience any sensitivity with hot or cold			
Name and location of previous Dentist:			
Name of your Medical Practitioner: Phone No.			
Please list any drugs or medicines you are allergic to:			
Please list any other known allergies (including latex, foods and preservatives):			

Please turn over

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Privacy Statement:
We value your privacy. All of the information which you prove to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take the time to read through our Privacy Policy before answering the questionnaire and speak to one of our staff members if you have any concerns.

Consent to treatment:
In signing this form, I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I understand that if I fail to give adequate notice to cancel my appointment, that a fee may be charged.
I agree to be responsible for the payment of all services rendered on my behalf and on the behalf of my dependents.
I understand that this payment is due at the time of service unless other arrangements have been made.

Patient (Responsible Party) Signature: _____ **Date:** _____

Office use Only: Reviewed by:	**Signature:**	**Date**

Practice Use Only: Review of information

Patient Signature: _____ **Date**: _____

Dentist Comments: _____

_____ **Date**: _____

Patient Signature: _____ **Date**: _____

Dentist Comments: _____

_____ **Date**: _____

Patient Signature: _____ **Date**: _____

Dentist Comments: _____

_____ **Date**: _____

Patient Signature: _____ **Date**: _____

Dentist Comments: _____

_____ **Date**: _____

Please turn over