WATTLE STREET DENTAL

Excellence by Choice

PERSONAL DETAILS

Title: _____ Full Name: _____ Date of Birth: ___/___/_____

Email: _____ Mobile: _____ Landline: _____

Residential Address: _____

_____

Postal Address (if different): _____

Health Insurance Fund: _____ Series #: _____ Occupation: _____

Medicare #: _____ Ref #: _____

Emergency Contact Name : _____ Number: _____

Relationship: _____

Do you identify as Aboriginal or Torres Straight Islander? Y / N Do you speak, read and/or understand English? Y / N

HOW DID YOU HEAR ABOUT US?

Drive/Walk by		Existing patient family		Channel 7	
Facebook		Instagram		Wattle Street website	
Google		Other			
Patient Referral (name of person):					

DENTAL AND MEDICAL HISTORY

Y / N Has your doctor advised you require antibiotic cover before dental treatments? _____

Y / N Do you have abnormal reactions to general anaesthesia? If yes: _____

Y / N Are you a current or past smoker? What do you smoke?: _____

When did you start?: _____ How many per day?: _____ When did you quit? _____

Y / N Would you like straighter teeth? Y / N Would you like whiter teeth?

Does dental treatment make you nervous? No Slightly Moderately Extremely

Current Medical Practitioner: Name: Location: _____

Dr Wei Shen, B.D.S. Adelaide Ph 5447 7669 | Shop 1/13 Garnet St. Cooroy QLD 456 | info@wattlestdental.com.au | www.wattlestdental.com.au

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	YES	NO		YES	NO		YES	NO
Heart Condition			**Stomach/ Digestive Condition**			**Bronchitis, emphysema or lung condition**		
High Blood Pressure			**Kidney Condition**			**Tuberculosis**		
Low Blood Pressure			**Liver Condition**			**Asthma**		
Rheumatic Fever			**Blood Disease/Disorder/ excessive bleeding**			**Hayfever**		
Heart Valve Condition			**Communicable Disease (eg, Hep, HIV)**			**Sinusitis**		
Heart Pacemaker			**Cancer**			**Sleep Disorder**		
High Cholesterol			**Radiation / Chemotherapy**			**Depression**		
Stroke			**Osteoporosis or low bone density**			**Anxiety**		
Auto-immune Condition			**Steroid therapy**			**Fainting**		
Thyroid Condition			**Organ Transplant**			**Epilepsy**		
Diabetes Type 1 / 2			**Joint replacement**					

Further details: _____

_____

	YES	NO	Details
Allergies or adverse reactions? (e.g. medications, foods, latex, pollen)			
Are you taking any medication to thin the blood?			
Are you taking any medications for your bones?			
Are you taking any other medications? Please list in full			
Are you taking any supplements? Please list in full			
Are you pregnant?			
I have confidential medical information that I wish not to write down. I would prefer to speak to a dentist about			

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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 anaesthetic and other medication as indicated and I will assume responsibility for the fees associated with those procedures. I hereby authorise the dentist to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to a thorough diagnosis.

RESCHEDULING APPOINTMENTS:

If at any time you need to reschedule your appointment, we appreciate having at least 48 hours notice (two business days). If you are unable to give this notice, a fee of $50.00 will occur.

PRIVACY POLICY

To provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address, and telephone number but it is also necessary for the dentist to obtain from you details regarding your general health and past medical and surgical events. Without this general health picture, the treating dentist is unable to plan your care properly. Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others. We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that: This information will only be used by the treating dentist in order to deliver your care to the highest standards. It will not be disclosed to those not associated with your treatment without your consent except as provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information. You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times. There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information. We will always take reasonable steps to ensure that the details we keep about you are accurate, complete and up to date. We will take reasonable steps to protect this information from misuse or loss and from unauthorised access, modification, or disclosure. Our staff are always trained to respect these principles.

PATIENT / PARENT / LEGAL GUARDIAN

Name: _____ Signature: _____

Updated: _____ Signature: _____

Updated: _____ Signature: _____