CENTRAL CANBERRA DENTISTS

NEW PATIENT DETAILS FORM

Welcome to our Dental Clinic.
We appreciate the confidence you place in us to provide you with quality dental services.
To assist us in helping you, please complete the following form.
If you have any questions, don't hesitate to ask.

Preferred title (Dr. Prof. Mr. Mrs. Ms. Miss. Mast.) _____

Surname _____

Given Names _____

Date of Birth _____

Address _____

_____

Telephone: Home_____

Work_____

Mobile_____

Email _____

Occupation _____

Place of work _____

Do you have Private Health Insurance? _____

If so, who with? _____

Membership Number _____ Series Number _____

How did you find out about us?

_____

Was this practice recommended to you? Yes / No

If so by whom? _____

Dr Lois Jun BDS (Adel.)

(02) 6249 8551 Suite 5 16 Moore Street Canberra ACT 2601
centralcanberradentists.com.au dental@centralcanberradentists.com.au

NEW PATIENT PAYMENT AGREEMENT

Dear Patient

We would like to welcome you to Central Canberra Dentists. Please read this agreement carefully. Should you have any questions, please ask us.

PAYMENT AGREEMENT

I,_____, authorise treatment for myself or a minor, and agree to pay all fees for such treatment. I authorise my dental insurance company or third party payer to make payments directly to Central Canberra Dentists, Suite 5 16 Moore St Canberra ACT 2600. I also authorise the release of protected information to my insurance company or third party payer for the purpose of reimbursement for services.
I understand that I am responsible for payment of any unpaid balance due from my insurance company or third party payer. I understand that any account, more than two months overdue, will be sent to a collections agency and I authorise the release of protected information for debt collection purposes. I further understand that I will be liable for all debt recovery fees.

ACKNOWLEDGEMENT OF TERMS

Payment for services may be made by credit card, approved cheque, or cash.
Full payment for services is due at the time of treatment.
Returned cheques will incur a $40.00 return fee.
We regret that we are unable to accept American Express

I have read and understood this document, and I agree to abide by its terms.

Signature (Patient or guardian) _____ Date_____

Signature (Witness) _____ Date_____

NEW PATIENT MEDICAL FORM

Welcome to our Dental Clinic. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. If you have any questions, don't hesitate to ask.

Preferred title (Dr. Prof. Mr. Mrs. Ms. Miss. Mast.)
Surname_____
Given Name_____ Date of Birth_____

DENTAL HISTORY

Do you feel nervous about dental treatment?	Yes	No
Have you had an unpleasant reaction following dental injections?	Yes	No
Do you gag easily?	Yes	No
Do your gums bleed easily? (e.g. when flossing or brushing)	Yes	No

How often do you brush?

_____

How often do you floss?

_____

MEDICAL HISTORY

Medical Dr's Name_____
Address/Location_____

Have you been hospitalized recently (give details)	Yes	No

_____

Are you presently receiving medical attention? (give details)	Yes	No

_____

What medications or drugs are you taking at present or have recently? (give details)

_____

_____

Are you allergic to (that is, experience itching, rashes, swelling of the eyes, tongue, hands or feet) or made sick by Penicillin, codeine, aspirin, sulphur. Latex or any other drugs?	Yes	No

_____

Have you ever had any excessive bleeding requiring special treatment?	Yes	No
Have you ever had any pain in your chest, shortness of breath or extreme fatigue?	Yes	No
Are you a smoker? If so, how many a day and how long have you been smoking?	Yes	No

_____

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Circle any of the following that you have had or have at present:

Heart failure Congenital heart disease Angina HBP LBP Rheumatic fever Heart surgery Heart pacemaker Heart murmur	Emphysema Chronic cough Tuberculosis (TB) Liver cirrhosis Hep A Hep B Hep C HIV AIDS	Stroke Blood transfusion Anemia Fainting or dizzy spells Bruise easily Haemophilia Autoimmune disease Dementia Creutzfeldt-Jakob disease	Asthma Hay fever Sinus trouble Allergies or hives Ulcers Arthritis Rheumatism Joint replacement	Diabetes Glaucoma Thyroid disease Cancer Radiation therapy Psychiatric treatment Drug addiction Dura Mata transplant

Do you have any bone disease? (Osteoporosis, Paget's disease, cancer with spread to bone, Multiple Myeloma, any other bone condition) Yes No

If yes, are you taking any of the bisphosphonate medications listed below?

Alendronate (Fosamax) Risedronate (Actonel) Pamidronate (Aredia, Pamisol) IV form Zoledronate (Zometa) IV form	Eitironate Clodronate Tiludronate

Do you have disease, condition or problem NOT listed above? Yes No

WOMEN: Are you pregnant? Yes No

Are you practicing birth control? Yes No

Is there any health matter you like to discuss privately with the dentist? Yes No

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or my medicines change, I will inform the dentist at my next appointment.

Signature of patient, parent or guardian **Date**

_____ _____