THE TOWNSVILLE DENTAL CENTRE®

Ph: (07) 4729 0241
Fax: (07) 4729 1045
www.thetownsvilledentalcentre.com
IN AN EXTREME EMERGENCY CALL 0467 618 697
Fairfield Waters Medical Centre
Shop 3 ,15-23 Kokoda St, Idalia QLD 4811
24hrs notice for cancellations is needed or fee will be charged

Title: Mr Mrs Miss Ms Dr Other: Date of Birth : _____ /_____ /_____

First Name : _____ Surname: _____

Address: Street : _____

State: _____ Postal Code: _____

Home No : _____ Work No : _____ Mobile : _____

Email Address: _____

Who can we thank for your referral : _____

Private Health Cover (if applicable) : _____

Occupation: _____

Primary Dental concern: _____

Are you pregnant ? _____

Do you require antibiotic cover prior to dental treatment ? _____

Please tick yes or no to the following questions :

Y	N		Y	N	
☐	☐	Heart Problems	☐	☐	Allergies to Anaesthetics
☐	☐	High blood pressure	☐	☐	Allergies to Penicillin or Medications
☐	☐	Low blood pressure	☐	☐	Allergies to Latex
☐	☐	Rheumatic Fever	☐	☐	Have you been diagnosed with HIV / Aids
☐	☐	Circulatory Problems	☐	☐	Anaemia
☐	☐	Radiation Treatment	☐	☐	Blood Disorders
☐	☐	Excessive Bleeding	☐	☐	Diabetes
☐	☐	Excessive Bruising	☐	☐	Hepatitis A B C D E
☐	☐	Ulcers (stomach)	☐	☐	Liver Problems
☐	☐	Sinus Trouble	☐	☐	Kidney Problems
☐	☐	Asthma	☐	☐	Tumor History
			☐	☐	Epilepsy

If you have ticked yes to any of the above please specify: _____

_____

Please list any Drugs or Medications you are currently taking: _____

_____

_____

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Have you had or do you suffer from any of the following?

Y	N	
☐	☐	Do you wear a dental night guard or a dental splint?
☐	☐	Have you ever had periodontal (gum) treatment?
☐	☐	Do you smoke?
☐	☐	Do you think you have occasional bad breath?
☐	☐	Do your gums ever bleed when you brush or floss
☐	☐	Does floss ever tear between your teeth?
☐	☐	Do you snore?
☐	☐	Is there anything else you would like us to know?

How often do you brush your teeth?

☐ occasionally ☐ once a day ☐ twice a day ☐ more than twice a day

How often do you floss?

☐ never ☐ 1 - 3 times a week ☐ 4 -5 times a week ☐ every day or more

The name of your physician: _____

Medical centre of your physician: _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken: ☐ Less than one year ☐ Longer than one year

If you could change your smile, what would you do? _____

Consent for Treatment

1. I herby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Name: _____ Date: _____

Name of Parent or Guardian if applicable: _____

Relationship to patient: _____

We expect and appreciate payment at time of service.
We accept all major credit cards, (visa, mastercard) personal cheque, eftpos and cash.
We require a minimum of 48hrs notice to change appointments otherwise a cancellation fee may apply.