Dr Axel Ecke
Dr Mary Phan
Dr Susana Le
Dr Luke Russell
Dr Fiona Chan
Dr Anik Saha
Dr Thanushan Raviendran
Basir Noorastani (Hyg)

# Welcome to our Practice.

TITLE □ Dr □ Mr □ Mrs □ Ms □ Miss □ Master

GIVEN NAME ……..SURNAMES ……DATE OF BIRTH …..…../……../……...

ADDRESS …….. SUBURB …….. POST CODE …….

TELEPHONE AH…….…… BH ……... MOBILE ...……..

EMAIL ADDRESS ……. PERSON RESPONSIBLE FOR FEES ……

HOW DID YOU FIND OUT ABOUT US? ……...

GENERAL PRACTITIONER DETAILS: Name…… Address…….

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OCCUPATION……... PLACE OF WORK ……

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□ EMERGENCY CONTACT or □ LEGAL GUARDIAN NAME……..

RELATIONSHIP…… PHONE ……. MOB…….....

PRIVATE DENTAL INSURANCE □ Yes □ No NAME OF H/FUND……..... PATIENT ID Please circle 00, 01,02,03,04

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## MEDICAL HISTORY *Tick any of the following that you **had** or **have present***

□ I would prefer to discuss these questions in private with the Dentist

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|---|---|---|---|
| □ Heart Ailment | □ High Blood Pressure | □ Excessive bleeding or blood disorders | □ Rheumatic fever |
| □ Kidney/Liver Disease | □ Diabetes Type…… | □ Stomach Ulcer or Bowel Problems | □ Asthma |
| □ Stroke | □ Chemo Or Radiotherapy | □ Chest or breathing problems | □ Thyroid |
| □ Fits or Epilepsy | □ Hepatitis | □ Bone disorders or disease | □ AIDS/HIV |
| □ History of CJ Disease | □ Women, Are you pregnant?...../ Weeks | | |

LIST ANY OTHER PREVIOUS ILLNESS…….....

DO YOU SMOKE □ Yes □ No HOW MANY? ……../Day WOULD YOU LIKE TO STOP? □ Yes □ No

How would you prefer to be notified for reminder recalls and appointments …… Post Mail □ Email □ SMS □ Phone call

| | | |
|---|---|---|
| Have you had any problems with dental treatment? ..... | □ Yes | □ No |
| Have/ Are you taking any medication for bone treatment? ..... | □ Yes | □ No |
| Do you have an artificial hip, heart valve or prosthetic implant? …… | □ Yes | □ No |
| Are you presently under medical care or taking any medications?..... | □ Yes | □ No |
| Are you ***allergic*** to any ***Drugs***, ***foods***, ***or*** ***Substances***…….. | □ Yes | □ No |

Please list any medication you are currently taking…….....

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk.

Comprehensive infection control procedures are performed in this practice. All personal information provided will be treated in the strictest confidence. **Cancellation fee applies if cancelled less than 24 hours' notice.**

**I understand that payment in full is due on the day of the appointment for treatment provided and any debt recovery fees will be at my own expense.**

Signed…….Date…….