

## Patient Information

Title: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Surname Given Name(s) (Preferred Name)

Date of Birth: \_\_\_\_\_ Are we able SMS appointment reminders? YES NO

Phone (H) \_\_\_\_\_ (W): \_\_\_\_\_ (Mob): \_\_\_\_\_

Which number is best for us to talk to you personally \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

## Spouse OR Responsible Party Information

The following information is for:  the patient's spouse  the person responsible for payment (Parent/Guardian)

Title: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Are you a patient at the Leeming Dental Centre? YES NO

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Mobile: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

## Employment Information

The following information is for:  the patient  the person responsible for payment (Parent/Guardian)

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

## Referral Information

May we know the reason for choosing our office? \_\_\_\_\_

To whom may we thank for recommending us? \_\_\_\_\_

Private Health Insurance: \_\_\_\_\_

## Consent for Services

*As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.*

*All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. We accept cash, EFTPOS and all major credit cards including AMEX and Diners Club. We also offer an interest free payment plan called GE Money Care Credit\*, that allows you to start treatment today and spread payments over time. Fees may also be charged for missed appointments or appointments cancelled without two working days notice.*

*I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and I further agree to be liable and pay upon demand any debt collection costs, legal costs and fees, missed appointment fees and dishonoured cheque fees that are associated with my account.*

*Unless I notify you otherwise, you may leave messages at work or with family members confirming my appointment times.*

*I have read the above conditions of treatment and agree to their content.*

\_\_\_\_\_  
Signature of **patient / parent / guardian** Date: \_\_\_\_\_

\_\_\_\_\_  
Staff Member Attending Date: \_\_\_\_\_

## Medical Information

Patient Name: \_\_\_\_\_

Surname

Given Names

Preferred Name

**Have you ever had any of the following? Please check those that apply:**

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Codeine Allergy    | <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Kidney Disease       | _____                                |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Blood Transfusion   | <input type="checkbox"/> Liver Disease        | _____                                |
| <input type="checkbox"/> Aspirin Allergy    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Pacemaker            | _____                                |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Pregnancy            | _____                                |
| _____                                       | <input type="checkbox"/> Diabetes            | <i>Due date:</i> _____                        | _____                                |
| _____                                       | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Radiation Treatment  | _____                                |
| <input type="checkbox"/> Anticoagulants     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Renal Dialysis       | _____                                |
| <input type="checkbox"/> Antidepressants    | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | _____                                |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | OTHER: _____                         |
|   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Medication   | _____                                |
|   | <input type="checkbox"/> HRT                 | <input type="checkbox"/> Tuberculosis         | _____                                |

- ✖ Have you ever had any complications following dental treatment?  Yes  No  
*If yes, please explain:* \_\_\_\_\_
- ✖ Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
*If yes, please explain:* \_\_\_\_\_
- ✖ Are you now under on going care of a doctor?  Yes  No  
*If yes, please explain:* \_\_\_\_\_
- ✖ Name of Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_
- ✖ Have you lost weight unintentionally?  Yes  No  
*If yes, please explain:* \_\_\_\_\_
- ✖ Have you been to a tropical area in the last 12 months?  Yes  No
- ✖ Have you had persistent diarrhoea, fever, night sweats or swollen glands?  Yes  No  
*If yes, please explain:* \_\_\_\_\_
- ✖ Have you taken or injected yourself with any substance NOT prescribed by a doctor?  Yes  No
- ✖ Do you have any health problems that need further clarification?  Yes  No  
*If yes, please explain:* \_\_\_\_\_
- ✖ Have you ever been treated with human growth hormone?  Yes  No
- ✖ Have you lived in the UK for 6 months or more between 1980 and 1996?  Yes  No
- ✖ Have you been exposed to Creutzfeldt-Jakob Disease?  Yes  No

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.**

\_\_\_\_\_  
Signature of patient / parent / guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_