Confident
HEALTHCARE

Personal & Contact Information
Updated

Mr /Mster/ Mrs / Miss / Ms First Name: _____ Surname: _____

Date of Birth: _____ / _____ / _____ Postal Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone: (H): _____ (W): _____ (M): _____

Email: _____

Occupation: _____

Next of Kin: _____ Relationship to you: _____ Ph: _____

Please give your Health Fund Card to our friendly receptionist at each visit.

Do you have Health Insurance? ☐ Yes ☐ No Health Fund Name: _____

Preferred method of payment? ☐ Eftpos ☐ Credit Card ☐ Cash ☐ Bartercard

I understand that all Dental treatment must be paid for on the day. Signature: _____

Medical History

Your Doctors Name: _____ Doctors Contact Number: _____

Do you, or have you experienced any of the following Conditions? (Please tick all that apply)

☐ Prosthetic Heart Valve ☐ Joint Prosthesis ☐ Stroke ☐ High Blood Pressure ☐ Hepatitis

☐ Asthma ☐ Infective Endocarditis ☐ Bleeding Disorder ☐ Heart Attack/Angina ☐ Smoker

☐ Rheumatic Fever ☐ Kidney Disease ☐ Heart Pacemaker ☐ Tuberculosis ☐ HIV/AIDS

☐ Diabetes ☐ Rheumatoid Arthritis ☐ Heart Murmur ☐ Liver Disease ☐ Epilepsy

☐ Currently Pregnant

☐ Previous Surgery (Please Specify): _____

☐ Other (Please Specify): _____ ☐ Allergies (Please Specify):_____

☐ Details of Current Medications: _____

☐ Have you ever used Botox or Filler (if so when): _____

Please let your dentist know if you would like to know how we use Botox and Filler to enhance your features and create the perfect smile.

If your medical conditions change at any time please inform the reception at your next visit.

The information provided is true to the best of my knowledge. I understand that failure to make full disclosure may place me in undue medical risk, and may compromise my dental treatment.

Signature: _____ Date: _____