CASTLE DENTAL

Title:	Surname:	First Name:
Address:		
	Postcode:	Date of Birth:
Contact Phone Numbers: (H) (M)		
Email Address: @		
Preferred Method for **Appointment Reminder**: ☐ SMS/Text Message ☐ Email ☐ Mobile Phone ☐ Home Phone		

Next of Kin: Relationship: Contact Phone Number:	Name of Employer: Occupation:

Medical History

Are you a Smoker? ☐ No ☐ Yes	Do you have Private Health Cover for Dental? ☐ No ☐ Yes Name of Private Health Fund:

Tick if you have any of the following:

☐ Anaemia	☐ Diabetes	☐ High Blood Pressure	☐Radiation Treatment
☐ Arthritis	☐ Epilepsy	☐ Low Blood Pressure	☐ Respiratory Disease
☐ Artificial Joints	☐ Fainting	☐ Hepatitis	☐ Rheumatic Fever
☐ Bleeding Disorder/ Haemophilia	☐ Heart Problems	☐ HIV/AIDs	☐ Shingles
☐ Asthma	☐ Artificial Heart Valve	☐ Kidney Disease	☐ Stroke
☐ Cancer	☐ Heart Murmur	☐ Liver Disease	☐ Thyroid Problems
☐ Chemotherapy	☐ Pacemaker	☐ Nervous Condition	☐ Tuberculosis

If yes to any of the above please give details:

Please list any medications you are on:	Please list any allergies you have:

I have reviewed the information provided and it is accurate to the best of my knowledge. I will let the dentist know of any changes to my medical history.

Where did you hear about us?

☐ Yellow Pages
☐ Yellow Pages Online
☐ Google
☐ Website

☐ Walked past
☐ Flyers
☐ Word of Mouth - Who can we thank for referring you?

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Do you have any concerns regarding the following issues when at the dentist? If so please indicate the level of concern you have with that issue.

☐ **Pain**

Minimal ——— Moderate ——— Extreme

☐ **Fear**

Minimal ——— Moderate ——— Extreme

☐ **Time**

Minimal ——— Moderate ——— Extreme

☐ **Cost**

Minimal ——— Moderate ——— Extreme

Do you have any other concerns? (please specify)

Thank you for choosing Castle Dental to provide your Oral Health needs. Please read the following policies, then sign your name and date where indicated.

We are a busy practice and we often have patients on our priority list who will be able to utilise your appointment time if you are unable to attend.

Cancellation\Fail To Attend (No Show) Policy

If you are unable to attend your scheduled appointment please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given I acknowledge that I will be charged a $50 deposit which in turn will be deducted from my next account. I understand these terms and I realise that I am financially responsible for charges incurred.

Privacy Policy

Castle Dental only collects information from our patients that is necessary in providing the best possible care and allows us to appropriately and thoroughly diagnose, treat and manage our patients. We aim to ensure that any information we hold is accurate, complete and up to date.

The health information that you provide is treated with the strictest of confidence and will only be disclosed to a third party (eg. health professional, insurance company etc) with your written consent, unless we are legally obliged to do so.

Castle Dental takes appropriate steps to ensure that all the information, photos, xrays etc we hold are protected from loss, misuse, or unauthorised access, disclosure or modification. All our staff are subject to strict obligations of confidentiality. I have read the above Cancellation Policy, Fail To Attend (No Show) Policy and Privacy Policy and consent.

Signature:______________________________ Date:____________________

(Parent/Guardian)