CASTLE DENTAL

PERSONAL DETAILS

Title:	Surname:	First Name:	Preferred Name:
Address:			
Suburb:	Postcode:	Date of Birth:	
Contact Phone Numbers: (Home)	(Mobile)		
Email Address: @			
Preferred Method for Appointment Reminder: ☐ SMS/Text Message ☐ Email ☐ Mobile Phone ☐ Home Phone			
Next of Kin: Relationship: 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 OR HAVE PREVIOUSLY HAD ANY OF THE FOLLOWING:

☐ Anaemia	☐ Chronic Fatigue	☐ High Blood Pressure	☐ Respiratory Disease
☐ Angina	☐ Chronic Pain	☐ Kidney Disease	☐Rheumatic Fever
☐ Arthritis	☐ Diabetes	☐ Liver Disease	☐Shingles
☐ Artificial Heart Valve	☐ Epilepsy	☐Low Blood Pressure	☐ Skin Condition
☐ Artificial Joints	☐ Fainting	☐ Nervous Condition	☐ Sleep Problems
☐ Asthma	☐ Glaucoma	☐ Nerve Problems	☐ Stroke
☐ Autoimmune Disease	☐ Hay fever	☐ Neurological Condition	☐ Thyroid Problems
☐ Bleeding Disorder/ Haemophilia	☐ Heart Problems	☐ Osteoporosis	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	
☐ Chemotherapy	☐ Hepatitis	☐ Radiation Treatment	
☐ Cholesterol problems	☐ HIV/AIDS	☐ Reflux	

If yes to any of the above please give details:	If you have any additional health issues, please list them:

Please list any **medications** you are on:	Please list any **supplements** you take:	Please list any **allergies** you have:
1. ______________________________	1. ______________________________	1. ______________________________
2. ______________________________	2. ______________________________	2. ______________________________
3. ______________________________	3. ______________________________	3. ______________________________
4. ______________________________	4. ______________________________	4. ______________________________
5. ______________________________	5. ______________________________	5. ______________________________

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 ☐ Walked past ☐ Word of Mouth - Who can we thank for referring you?
☐ Google ☐ Social Media ____
☐ Website ☐ Flyers

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.

<u>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.</u>

Cancellation\Fail To Attend (No Show) Policy

If you are unable to attend your scheduled appointment please call us ASAP (48 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 48 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.

As part of our commitment to ongoing patient care you will receive information on oral health and hygiene.

I do not wish to receive these emails. ☐

Signature:____ Date:____________________

(Parent/Guardian)