Signature Smiles DENTAL

Dr/ Prof/ Mr/ Mrs/ Ms/ Miss/ Master

Surname: _____ First Name: _____

Address: _____ Suburb: _____

Post Code: _____ Occupation: _____

Date of Birth: _____ Work Number: _____

Home Number: _____ Mobile Number: _____

Name of Dental Health Fund: _____

Fund Membership Number: _____ Member I.D: (please circle) 00 | 01 | 02 | 03 | 04 | 05

Medicare Number: _____ Member I.D: (please circle) 00 | 01 | 02 | 03 | 04 | 05

Medicare card Expiry: _____

Email Address: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you hear about us? (Please circle and specify)

Internet (eg. Facebook, Google) _____ Personal referral (Patient's Name) _____

Advertisement (eg.Invisalign or Botox Flyer) _____ Other _____

Do you feel nervous about dental treatment? Yes / No (Please circle)

Date of last dental treatment? _____

Are you currently undergoing any medical treatment or taking any medication? Yes / No (Please circle)

If yes, name of medication and dosage: _____

Physicians Name: _____ Phone: _____

Do you have any allergies? eg. Penicillin, Aspirin, Codeine, Erythromycin. Yes / No (Please circle)

If yes, please specify: _____

Have you had or are presently being treated with Botox and/or Dermal fillers? Yes / No (Please circle)

Please indicate below if you have had or have presently any of the following: (Please circle)

Arthritis/ Rheumatism Yes / No	Fainting / Dizzy Spells Yes / No	Radiation / Chemotherapy Yes / No
Artificial Joints (hip, knee) Yes / No	Haemophilia Yes / No	Sinus troubles Yes / No
Asthma Yes / No	Heart Conditions Yes / No	Stomach Ulcers Yes / No
Diabetes Yes / No	Hepatitis (A / B / C) Yes / No	Stroke Yes / No
Emphysema / Chronic Cough Yes / No	High Blood Pressure Yes / No	Thyroid Problems Yes / No
Epilepsy Yes / No	HIV / AIDS Yes / No	Other: _____

Are you pregnant? Yes / No / Maybe (Please circle) Breastfeeding? Yes / No (Please circle)

Are you a smoker? Yes / No (Please circle) If yes, how many per day? _____

Are you interested in the following or in receiving emails on hygiene techniques and special offers? (Please circle)

Whitening	Tooth Replacement	Teeth Straightening	Sleep Disorder
Botox/Dermal fillers	General Anaesthesia/Sedation	General Newsletter	

I, the undersigned consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures. I understand the practice requires 48 hours notice if I need to cancel or reschedule my appointment. I am aware payment is required on the day of treatment. In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.

Patient/Parent/Guardian Signature: _____ Date: _____