Welcome to Portside Dental. Please complete the following confidential medical history form. Please take care to fill out this form completely, we rely on all your information to be able to provide you with the most appropriate dental care.

CONTACT DETAILS

Preferred title: ______________ Last Name: ______________________________
Given Names: ______________________________ Preferred Name: ______________
Date of Birth: _______/_____/______________ Contact Phone: ______________
Address: ______________________________ Suburb: ______________
Postcode: ___________ Email: ______________________@______________
Parent / Guardian name (if applicable): ______________ Contact Phone Number: __________
Emergency Contact Name: ______________________ Contact Phone Number: ______________
How did you hear about us?: ______________________________

MEDICAL HISTORY

To the best of your knowledge do you have or have you suffered from the following?

□ High Blood Pressure □ Joint Replacement □ HIV / Aids □ Disability □ Cancer
□ Hepatitis B/C □ Excessive Bleeding □ Gastric Reflux □ Asthma □ Diabetes
□ Sleep Apnea □ Heart Valve Replacement □ Heart Disease □ Epilepsy □ Autism
□ Osteoporosis/Bisphosphonate Treatment

Any Other Serious Health Issues or Surgery? ______________________________
Any Known Allergies? ______________________________
Please list any medications that you are currently taking or have taken recently (including natural therapies). A list from your GP can be attached: ______________________________
____

Do you smoke? Yes □ No □

Ladies, Are you pregnant? If so, how many weeks? _____
Ladies, Are you breastfeeding? □ Yes □ No

DENTAL HISTORY

Approximately, when was your last visit to the dentist? ______________________________
What are your dental concerns?

□ Pain/Sensitivity □ Missing Teeth □ Gum Problems □ Worn down / Broken teeth
□ Jaw Pain / Headaches □ Crooked Teeth □ Denture Problems □ Issues with Fillings

Would you like to know more about any of the following?

□ Invisalign □ Teeth Whitening □ Veneers
□ Sleep Dentistry □ Implants □ Botox/Fillers

Are there any other dental concerns you would like to discuss? ______________________________

ACCOUNT DETAILS

Person responsible for the fees? □ Self □Other Name: ______________________________
Do you have Private Health Insurance? □ Yes □ No Fund: ______________________________
Are you eligible for the Child Dental Benefits Schedule? □ Yes □ No
Are you covered by Veterans Affairs? □ Yes □ No Card Number: ______________________________

APPOINTMENT REMINDERS

We send appointment reminders 2 days prior to the appointment, would you prefer? □ SMS □ Phone Call
How would you like to receive your regular check up and clean reminder?
□ Email □ SMS □ Phone call □ Mail □ None

Please read & sign the next page

Privacy Policy – We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception. We may also use de-identified before and after photos for the purposes of advertising.

Payment Policy – Payment is required on the day of treatment. Any accounts that are overdue and additional costs are incurred due to debt collection fees charged by an external agency, will be passed on to the patient.

Cancellation Policy – We require 24 hours notice for re-scheduling of appointments. If less that 24 hours is given a fee will be charged.

Patient / Guardian Signature: ____ Date: ______________

Portside Dental was born from the desire to take a different approach to dentistry and we value feedback from you to ensure we maintain the high standards we aim to achieve for each and every patient.

If you are happy with our service – please leave us a Google Review. If you have any concerns with your visit, please contact our practice manager, Rachael 9967-6131.

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