SOUTH BURNETT DENTAL GROUP
beautiful, healthy smiles

Office Use Only
Provider - AH / KC / NB / WL / PK
❍ Entered ❍ Scanned

Patient Acquaintance Form

Our friendly team welcomes you!

Please take your time to provide the following information as accurately as possible.
Your co-operation assists us in providing you with the best possible treatment and care.

Personal Details –

Surname:	**Mobile:**
Title: Mr / Mrs / Miss / Ms / Dr / Master / Other:	**Email Address:**
First Name:	**Private Dental Insurance: ❍ Yes ❍ No**
Preferred Name: (If different)	**If yes, name of health fund: Ref No:**
Date of Birth:	**How did you hear about us?** ❍ Yellow Pages ❍ Newspaper ❍ Personal Referral ❍ GP ❍ Google
Residential Address: **Town: Post Code:**	**If personal referral, please provide name:**
Postal Address: **(If different)**	**Emergency contact name:** **Phone:**
Home Phone:	**Prefer contact method: ❍ Phone ❍ SMS Mobile**
Work Phone:	**Your Doctor (GP):**

Medical History – please indicate if you ***currently have*** or have ***ever had*** –

Angina / chest pain / heart attack (circle)	**❍ Yes ❍ No**	**Steroid therapy**	**❍ Yes ❍ No**	**Asthma / Respiratory problems (circle)**	**❍ Yes ❍ No**
Heart valve repair / replacement / defibrillator (circle)	**❍ Yes ❍ No**	**Artificial joints / transplant (details)**	**❍ Yes ❍ No**	**Sinus problems**	**❍ Yes ❍ No**
Cardiac pacemaker / heart conditions / murmur (circle)	**❍ Yes ❍ No**	**Blood pressure problems HIGH / LOW (circle)**	**❍ Yes ❍ No**	**Excessive bleeding / bruise easily (circle)**	**❍ Yes ❍ No**
Rheumatic fever	**❍ Yes ❍ No**	**Hepatitis A / B / C (circle)**	**❍ Yes ❍ No**	**Epilepsy / seizures (circle)**	**❍ Yes ❍ No**
Stroke	**❍ Yes ❍ No**	**Jaundice / Liver disease (circle)**	**❍ Yes ❍ No**	**History of fainting**	**❍ Yes ❍ No**
Diabetes – Type 1 / 2 (circle)	**❍ Yes ❍ No**	**Aids / HIV (circle)**	**❍ Yes ❍ No**	**Taken Osteoporosis medications (Actenol / Fosamax**	**❍ Yes ❍ No**
Cancer	**❍ Yes ❍ No**	**Other infectious disease**	**❍ Yes ❍ No**	**Do you smoke or use other forms of tobacco**	**❍ Yes ❍ No**
Radiation / chemo therapy to neck or head (circle)	**❍ Yes ❍ No**	**Anxiety / depression (circle)**	**❍ Yes ❍ No**	**Have you been medically advised to take Antibiotic cover prior to receiving dental treatment**	**❍ Yes ❍ No**

Have you had any other serious illness? If so please state,

_____

Please turn over

Medications – Are you taking any prescription/non-prescription drugs, herbal remedies or vitamins at present?

❍ Yes ❍ No (**Please attach separate list if more space required)**

Medication Name	Taken for	Dosage (if known)

Allergies – please indicate if you have had an allergic or negative reaction to any or the following –

Local Anaesthetic	**❍ Yes ❍ No**	**Sedatives / Barbiturates**	**❍ Yes ❍ No**	**Penicillin or antibiotics**	**❍ Yes ❍ No**
Latex	**❍ Yes ❍ No**	**Anti-inflammatory medication**	**❍ Yes ❍ No**	**Codeine**	**❍ Yes ❍ No**

Do have any other allergies? ❍ Yes ❍ No Details _____

Women Only – Are you, or suspect you may be pregnant? ❍ Yes ❍ No If yes, due date ____ / ____ / ____

Are you breast feeding? ❍ Yes ❍ No

My Dental History –

When was your last dental exam or x-rays taken? _____

What is the purpose of your visit today? _____

Do you wear Dentures? _____ If yes, approximately how old are they? _____

Are you happy with your current dental appearance? ❍ Yes ❍ No

If No, what changes are you hoping for? _____

Have you had any problems or bad experiences with dental treatment in the past? _____

Missed appointment and Payment –

1. We understand that life can be hectic at times and it can be difficult to remember everything on your schedule. So that we can provide the best service to our valued clients, it is our policy, that if you *miss an appointment and do not contact us*, you may be asked to pay a $100.00 bond, *before we will see you for further treatment*.
2. If you need to reschedule or cancel your appointments, please provide us with at *least **48 hours notice*.** This will enable us to help someone else with their dental needs.
3. Payment is expected in full on the day of treatment please.

I understand that the above information I have provided is necessary to provide safe and efficient dental care. I have answered all questions to the best of my knowledge. Should you need any further information, you have my permission to contact my health care provider, who may release such information to you. I shall notify the Dentist/ Reception of any medical changes.

I agree to pay for my treatment in full on the day.

Signature _____ Date _____

Thank you for your co-operation!