DentalonMetro
THE SMILE PROFESSIONALS

Ground Floor, Club Metro Building
27-29 Metro Parade
Mawson Lakes SA 5095
PH: (08) 8260 1007
www.dentalonmetro.com.au
enquiry@dentalonmetro.com.au

Like us on facebook
for Special offers, healthy tips, & more...

PATIENT ACQUAINTANCE FORM

Thank you for choosing Dental on Metro, we look forward to helping you with your smile.

Please complete this form. A copy may be saved for your own records.

The information you provide to us on this form is strictly confidential. It will be used strictly in accordance with *The Privacy Amendment Act 2012* (Cth) and its regulations. Your information will not be released to any third parties without your prior written consent.

Date: _____

NOTES & INSTRUCTIONS

1. This is an electronic form and should be completed using Adobe Reader or Acrobat (version 8.1 or greater) on your Mac or PC computer.
   IMPORTANT: If you are using a Mac computer, please ensure the form is NOT opened within Apple "Preview" - *Mac's default PDF viewer.* Instead, first save this form to your computer, then launch the Adobe Reader/Acrobat application. Once the application is running, open this form by selecting File>Open from the top menu. Failure to follow these instructions may result in your form not functioning properly once returned to our office.
2. If you have filled out the following form before, you are being sent the form again to update your details.
3. To reduce administration time, we would be grateful if you could fill out the relevant details on this form **prior** to attending our practice.
4. Once completed, printing and/or signing the form is NOT required. We will do this on attendance at our surgery.
6. Please email the completed form to **enquiry@dentalonmetro.com.au**. NOTE: For added convenience, if you use an Email Client to send email (i.e. Microsoft Outlook, Apple Mail, etc.) you may use the "Submit via Email" button provided on page 2. After you have sent the form, please verify successful transmission by checking your Sent mail folder. You may also contact our office to verify receipt (please allow up to 30 mins. following email submission).
7. On attendance at our surgery we will ask you to sign the form.

Thank you for your assistance.

PATIENT INFORMATION

Please take time to answer the questions as completely as possible. We wish to give you the best dental care.

SURNAME: _____ FIRST NAME: _____

PREFERRED NAME: _____ TITLE: _____ DATE OF BIRTH: _____

ADDRESS: _____ POSTCODE: _____

EMAIL ADDRESS: _____

CONTACT NUMBERS H: _____ W: _____ MOB: _____

OCCUPATION: _____ EMPLOYER: _____

NEAREST RELATIVE (Not at your address): _____ PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

PERSON RESPONSIBLE FOR PAYMENT: _____

WHAT HEALTH FUND ARE YOU WITH? _____

HOW DID YOU DISCOVER US? _____

REASON FOR YOUR INITIAL VISIT:

CONFIDENTIAL MEDICAL HISTORY

Please answer ALL the following questions.

DO YOU TAKE DRUGS OR PRESCRIBED MEDICINE REGULARLY? IF YES, PROVIDE DETAILS:

HAVE YOU HAD A BAD REACTION TO ANY TREATMENT OR MEDICATION? IF YES, PROVIDE DETAILS:

HAVE YOU HAD ANY SERIOUS HEALTH PROBLEMS DURING THE LAST YEAR? IF YES, PROVIDE DETAILS:

DO YOU SMOKE? ☐ Yes ☐ No

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

RHEUMATIC FEVER ☐ Yes ☐ No

HEART DISEASE *(including surgery, murmur, coronary, valve problems)* ☐ Yes ☐ No

If YES, provide details:

HEART VALVE REPLACEMENT ☐ Yes ☐ No

HIGH BLOOD PRESSURE ☐ Yes ☐ No

ANAEMIA ☐ Yes ☐ No

BLOOD TRANSFUSION ☐ Yes ☐ No

ARTHRITIS ☐ Yes ☐ No

DIABETES ☐ Yes ☐ No

EPILEPSY ☐ Yes ☐ No

ARTIFICIAL JOINT REPLACEMENT ☐ Yes ☐ No

LIVER OR KIDNEY DISEASE ☐ Yes ☐ No

ASTHMA ☐ Yes ☐ No

ALLERGIES ☐ Yes ☐ No

STEROID THERAPY ☐ Yes ☐ No

RADIATION/CHEMOTHERAPY ☐ Yes ☐ No

HIV ☐ Yes ☐ No

HEPATITIS - TYPE: _____ ☐ Yes ☐ No

ALLERGIC TO LATEX RUBBER? ☐ Yes ☐ No

ARE YOU PREGNANT? ☐ Yes ☐ No

ARE YOU APPREHENSIVE ABOUT DENTAL TREATMENT?

IF YES, PLEASE SELECT ONE OF THE FOLLOWING: ☐ Mild ☐ Moderate ☐ Very

Please note cancellation without 24 hour prior notice may incur a $100 Cancellation Fee.

As I am seeking private treatment, I understand that the payment of the account is my responsibility. I undertake to pay any additional expenses incurred in recovering overdue accounts.

I agree to disclose the nature of my dental treatment in relation to claiming insurance entitlements, via electronic transfer.

NOTE: Signing this form is not required until attendance at surgery. Please email unsigned.

SIGNED: _____ DATE: _____

Submit via Email