Patient Details

CROYDON CENTRAL DENTAL

Personal details

Title **First name** **Surname**

Preferred name Date of birth / /

Health Insurer Member number

Occupation

Contact details

Email

Contact Number 1 Contact Number 2

Address

Suburb State Postcode

I agree to the collection and use of my personal information above to aid in my treatment. Our privacy policy is available on request.
So that we can be fair in allocating appointments to others, if you need to reschedule your appointment please give us at least 24 hours notice. Unattended appointments with less than 24 hours notice may incur a fee of $75. You are able to change your appointments via email anytime or by calling our office number during business hours.

Medical Information

When was your last dental check-up? .....

Do you have or have you had any of the following medical conditions? (Please tick No or Yes)
For all medical conditions marked as 'Yes' please consult your practitioner during your appointment.

Cardiovascular disease	Y ☐ N ☐	Diabetes	Y ☐ N ☐	Liver Function Issues	Y ☐ N ☐
High blood pressure	Y ☐ N ☐	Osteoporosis/Arthritis	Y ☐ N ☐	Autoimmune disorders	Y ☐ N ☐
Excessive bleeding	Y ☐ N ☐	Gastrointestinal problems	Y ☐ N ☐	Lung Problems	Y ☐ N ☐
Rheumatic fever	Y ☐ N ☐	Kidney problems	Y ☐ N ☐	Thyroid problems	Y ☐ N ☐
HIV and / or Hepatitis	Y ☐ N ☐	Nervous system disorders	Y ☐ Y ☐	Pregnant	Y ☐ N ☐

Previously admitted to hospital or had an past operation Y ☐ N ☐ .....

I am, or have recently undergone, chemotherapy or radiation therapy. Y ☐ N ☐ .....

Do you have any allergies? Y ☐ N ☐ (details) .....

Do you smoke? Y ☐ N ☐ If yes, how long ..... how many per day .....

Do you take medication? Y ☐ N ☐ (Name) .....

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Emergency contact

Name: ..... Phone: ..... Relationship: .....

How did you hear about us

Family/Friend ☐ Croydon Central Marketing ☐ Google/Website ☐ Other ☐

Staff member ☐ Letter drop ☐ Walking by ☐ Referred by: .....

I acknowledge that the medical information I have provided is true and accurate at the date of my appointment and I have disclosed any medications or conditions that may affect orinfluence my treatment. Payment on the day of treatment is required.

Patient signature: ✘ ..... Date: .....

Dentist signature: ..... Dentist name (print) .....