

*We love to make life easier for you! In order to best serve your needs, we thank you for spending a few minutes to carefully read and fill out this form.*

**Dental Quarters Team.**

Dental Quarters Claremont  
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Recommended

## Patient information

Mr / Mrs / Ms / Dr / Miss/ Master

Surname:

First:

Middle Initial:

Marital status:

Single/Mar/Partner

Preferred Name:

Date of birth:

Age:

Sex: ☐ M ☐ F Email:

Address:

Suburb:

Post code:

Home phone number:

Mobile number:

Occupation:

Person responsible for bill (if not self)

Billing address: ☐ same as above

**Recommended by:**

(We would like to personally thank the people who help support us so please dob them in!)

**Purpose of visit:**

Dental insurance:

Member No:

Reference No:

Is another family member a patient at our office: ☐ Yes ☐ No

## In case of an emergency

Name of local friend or  
relative (not living at same  
address)

Relationship to patient:

Home phone no:

Work phone no:

( )

( )

# Medical Form

Medical Physician:

Medical Physician's Phone #:

## Personal Health History

Allergies

☐ Latex

☐ Penicillin

☐ Other

☐ Codeine

☐ Metal

☐ Acrylic

☐ Local Anesthetics

List any medications you are currently taking (including aspirin):

Have you had any Botox or Fillers before?

Have you had any of the following?

☐ Heart problems

☐ Ulcers (stomach

☐ Congenital Heart Disease (inc Rheumatic Fever)

☐ Sinus trouble

☐ Mitral Valve Prolapse

☐ Asthma/breathing problems

☐ High blood pressure

☐ Thyroid problems

☐ Artificial heart valve

☐ Kidney problems

☐ Stents

☐ Epilepsy/Seizures

☐ Stroke

☐ Diabetes

☐ Pacemaker

☐ Neurological disorders

☐ Artificial joints/Pins/ Plates

☐ Psychiatric/Psychological

☐ Radiation Treatment

☐ Liver Disease

☐ Excessive bleeding &/or bruising

☐ Hepatitis A B C

☐ Anaemia or other blood disorders

☐ HIV

Are you pregnant?

Do you smoke?

Do you know of any reason you are required to take a pre-medication antibiotic prior to medical or dental treatment?

☐ Any conditions not listed:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dental Form

How long since your last dental appointment?

Previous dental x-rays were taken:

☐ Less than a year ago

How often do you have dental check-ups?

☐ More than a year

Have you had any of the following?

☐ Sore jaw

☐ Occasional bad breath

☐ Clench or grind teeth

☐ Bleeding gums when you brush

☐ Wear a night guard

☐ Sensitivity to hot/cold

☐ Clicking/Popping jaw

☐ Floss tears or gets stuck between your teeth

☐ Limited mouth opening

☐ Food gets jammed between your teeth

☐ Orthodontic treatment

☐ Teeth hurt when you bite

☐ Gum disease

☐ Anything else?

### Consent for treatment:

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I authorise that this data may be review by team members of the dental practice.

### Credit/Other Terms:

Payment is required on the day of the treatment unless otherwise arranged by the Dentist or Treatment Coordinator.

I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

If not paid a 25% administration fee will be added. Any costs or legal fees incurred in the collection of outstanding accounts are the responsibility of the account payer.

To change or cancel an appointment requires a minimum of 24hrs notice. Missed appointments may incur a fee of up to \$60.00, depending on the length of appointment/s.

The above information is true to the best of my knowledge and I agree to the terms listed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/responsible party's signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_