Dr Diane Dawes B.D.S.(Hons)

42 Mary Street
Noosaville 4566
Sunshine Coast

Thank you for choosing our services.
The following information is required to provide the best possible dental care.
ALL INFORMATION IS STRICTLY CONFIDENTIAL

Dr. Mr. Mrs. Miss. Ms (please circle)
Name in full: ……………………………………………………………………………….
Preferred Name: …………………………………………………………………………..
Date of birth: …………/ …………. / …………………
Residential Address ………………………………………………………………………..
………………………………………………………. Postcode …………………………..
Postal Address ……………………………………………………………………………..
………………………………………………………..Postcode ………………………….
Phone Home: ………………..Work ……………………… Mobile ……………….
In Case of Emergency Phone Number: ………………………………………………..
Occupation/School …………………………………………………………………….
Employer ………………………………………………………………………………….
Do you have private dental health cover/which fund? ………………………….
Patient ref. no ……………………………………………………………………………
Medicare no: ……………………………………………… Patient ref. no …………..
Who referred you to this practice? ………………………………………………………
What is the reason for your visit today? ……………………………………………
Please list any concerns or problems that you may have with your teeth or mouth.
……………………………………………………………………………………………..
……………………………………………………………………………………………..
Clinical photos of your teeth may be taken during treatment. Do you consent for us to use them for internal advertising? ……………………………… yes/no

PAYMENT: Please understand that payment is required at the completion of each visit, either by cash, cheque or credit card. If your cheque is returned by the bank this will incur a $30 fee. If payment is not received within 7-14 days the matter will be referred on to our collection agency. If this course of action becomes necessary, then all costs of recovery become your responsibility.
CANCELLATION: Appointments cancelled with less than 24hrs notice will be subject to a failure fee.

Our practice is currently undergoing accreditation. If you have any questions about our infection prevention and control measures please do not hesitate to ask.

Patients (Parents/Guardians) signature……………………………. Date …/ … / …..

MEDICAL HISTORY (circle one)

It is important to know details about your history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy.

Do you normally require antibiotic cover before dental treatment............. yes/no
Have you had any abnormal reactions to local or general anesthesia? …… yes/no
Do you smoke? ………………………………………………………………....... yes/no
Are you pregnant? (women only) …………………………………………….... yes/no
Are you being treated by a doctor at present? …………………………….... yes/no
Have you been hospitalized in the last 12 months? ……………………….... yes/no
Have you or anyone in your household returned from overseas travel
in the last 10 days? ……………………………………………………………..... yes/no
Are you taking any prescription or other medications at present? ………. yes/no
Please list current medications ……………………………………………….
……………………………………………………………………………….
……………………………………………………………………………….
Please list any drugs or medicines you are allergic to ……………………….
……………………………………………………………………………….
Please list any other allergies (including latex, foods and preservatives) ….
……………………………………………………………………………….
Do you have or have you ever had any of the following medical conditions?

Steroid therapy …………… yes/no
Rheumatic Fever ……….. yes/no
Epilepsy ………………….. yes/no
Asthma ………………….. yes/no
Diabetes ………………… yes/no
Heart disorder/complaint … yes/no
Bone disease including
osteoporosis ……………… yes/no
Radiation therapy ………… yes/no
Prosthetic implant ………. yes/no
Stomach or digestive cond yes/no
Contact with blood-borne
viruses …………………… yes/no
Anaemia, leukemia or
other blood diseases …… yes/no

Kidney disease ………………… yes/no
Excessive bleeding …. ……… yes/no
Stroke ……………………….. yes/no
Cancer ………………………. yes/no
Tuberculosis ………………… yes/no
Thyroid disease ……………… yes/no
Nervous or psychiatric
condition ……………………… yes/no
High/low blood pressure …….. yes/no
Cardiac pacemaker …………….yes/no
Hepatatis or liver diseases …… yes/no
Bronchitis, emphysema
or other lung diseases ……… yes/no
Any other conditions ……… yes/no

Have you ever had any reactions to dental injections? ………………… yes/no
Have you ever had any difficult extractions? ……………………………… yes/no
Who is your doctor? ……………………………………………………..

Patients (Parents/Guardians) signature…………………………….
(Print name) …………………………………………………… Date …/ … / …..