It is important to know details about your medical history as these could affect the success of your dental treatment and 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 which is shown on the reverse of this form.

Title (eg Mr/Mrs/Ms):..... Last Name: .....
Date of Birth: ..... First Name: .....
Home Address: ..... Postcode: .....
Postal Address: ..... Postcode: .....
Mobile: ..... Home: ..... Email: .....
Name of Emergency Contact Person: .....Their Phone No:.....

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this (please tick box). •

	No	Yes	List Medications
Do you normally require antibiotic cover before dental treatment?			
Have you had any abnormal reactions to local or general anaethesia?			
Do you smoke?			
Are you pregnant? (Females only)			
Are you being treated by a doctor at present?			
Are you taking any prescription or other medications at present?			
Have you been hospitalised in the last 12 months?			
Have your or anyone in your household returned from overseas travel in the last 10 days?			

Who is your doctor? ……
Please list any drugs or medications you are allergic to: ……
Please list any other known allergies (including latex, foods and preservatives): .....

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please circle either yes or no for each condition

Steroid therapy	yes/no	Kidney disease	yes/no
Rheumatic fever	yes/no	Excessive bleeding	yes/no
Epilepsy	yes/no	Stroke	yes/no
Asthma	yes/no	Cancer	yes/no
Diabetes	yes/no	Tuberculosis	yes/no
Heart disorder/complaint	yes/no	Thyroid disease	yes/no
Bone disease including osteoporosis	yes/no	Nervous or psychiatric condition	yes/no
Radiation therapy	yes/no	High/low blood pressure	yes/no
Prosthetic implant	yes/no	Cardiac pacemaker	yes/no
Stomach or digestive condition	yes/no	Hepatitis or liver diseases	yes/no
Contact with blood-borne viruses	yes/no	Bronchitis, emphysema or other lung diseases	yes/no
Anaemia, leukemia or other blood diseases	yes/no		
Any other conditions			

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

……

I have read and accepted the Missed appointment/Late Cancel Policy on the back of this form

Your/Guardian's signature…… Date: .....

dr.diane dawes B.D.S.(Hons)

42 mary street
noosaville 4566
Tel: 5474 3131

Missed Appointment/Late Cancel Policy

We feel the dentist/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy. We understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment. Please see our missed/cancelled appointment guidelines below.

If you are unable to keep your schedule appointment, we require a 24-hour notice (1 full business day) so that we may accommodate the dental needs of another patient. This guidance applies to both visits with our hygienist and our dentists. If an appointment is cancelled or reschedule within 24 hours of the reserved appointment time, Simply Dental may charge the patient a cancellation fee.

Hygiene Visits: A $50 will be charged to the patient account for any late-cancel/failed appointments.

Doctor Visits: Because we do not schedule several operative patients at the same time, all appointments are reserved exclusively for you. In the event of a late cancel/failed dentist appointment, the patient will be charge a fee to the value of the missed appointment, if the appointment cannot be filled.

Thank you for choosing Simply Dental as your dental health provider.

Dr Diane Dawes, Dr Catriona MacRae