DELLAMALVA DENTAL

CROYDON
217 Torrens Road
Croydon SA 5008
P: 08 8346 8373

VIRGINIA
1/1 Old Port Wakefield Road
Virginia SA 5120
P: 08 8380 9461

dellamalva.dental@gmail.com // dellamalvadental.com

PATIENT DETAILS

Title:	Surname:	First Name:	Preferred Name:
DOB:	Email:	Phone:	Mobile:
Home Address:		Suburb:	Postcode:
Billing Address:		Suburb:	Postcode:
Occupation:		Employer:	

What is your **Medicare** no:

Expiry:	Ref No:

Do you have **Private Health Insurance** Extras Cover? **Y** **N**

Name of Insurance Provider:	Ref No:	Membership No:

Parent / Guardian Name (if applicable):
One Parent/Guardian must be available to give consent for treatment of children under the age of 16.

Relationship to Patient:	Mobile/Other No:
Emergency Contact Name:	Relationship to Patient:
Best Contact No:	

How did you hear about us? (please tick one of the following):

☐ Friend / Relative (name):	☐ Facebook	☐ Searching Online
☐ Drive / Walk By:	☐ Other please specify	☐ Searching Online

MEDICAL HISTORY

Physician:	Phone Number:
Address:	

Current Medication: If you are taking any medication, pills or drugs please list below.

Do you have or have you had any of the following medical conditions? (please tick if any of the following are applicable)

☐ Stroke/Heart Attack	☐ Pacemaker	☐ Artificial Heart Valves	☐ Artificial Joint (specify): ________
☐ High/Low Blood Pressure	☐ Excessive Bleeding/Bruising	☐ Rheumatic Fever	☐ Heart Murmur
☐ Diabetes (circle): Type I / Type II	☐ Lung Problems	☐ Kidney Problems	☐ Mental Illness (specify): ________
☐ Asthma	☐ Thyroid Disorder	☐ Liver Problems	☐ Anxiety/Depression
☐ Sinus Issues	☐ Arthritis	☐ Osteoporosis	☐ Epilepsy

☐ Are you Pregnant? (due date): ____________________ ☐ Do you Smoke?

☐ Cancer: Past/Present (specify): ____________________ ☐ Hepatitis (specify): ____________________

☐ Have you ever had blood work for infectious diseases? (please specify. Eg HIV):

Allergies (please tick if any of the following are applicable):

☐ Latex ☐ Penicillin ☐ Aspirin ☐ Iodine ☐ Sulphur ☐ Codeine ☐ Other (specify): ____________

☐ Reactions/Allergies to Local Anesthetic (please specify): ____________________

Have you ever been hospitalised? (if yes, please specify):

Please turn over

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DENTAL HISTORY

Do you have any immediate dental concerns / problems? (please specify)

Have you had dental xrays in the last 2 years? **Y / N**

When was your last professional clean?

Are you concerned about any of the following that you wish to discuss with us (please tick if any of the following are applicable)

- ☐ Bad appearance of teeth
- ☐ Discoloured teeth
- ☐ Lost filling / cavity
- ☐ Toothache
- ☐ Bad breath
- ☐ Dry mouth
- ☐ Rapidly decaying teeth
- ☐ Teeth whitening
- ☐ Bleeding gums
- ☐ Grinding / clenching
- ☐ Pain: face / jaw
- ☐ Unsatisfactory denture
- ☐ Clicking jaw
- ☐ Missing teeth
- ☐ Sensitive teeth
- ☐ Worn of broken teeth
- ☐ Difficulty chewing
- ☐ Loose teeth

Have you ever had a sleep study and been diagnosed with sleep apnoea? **Y N**

Has anyone ever told you that you snore? **Y / N**

THE FORMALITIES

Privacy Policy:
All personal information collected by Dellamalva Dental is strictly confidential and handled in accordance with our privacy policy. By signing this form you hereby agree and acknowledge that you have accurately completed this new patient medical history form to the best of your knowledge.

Initial for Acknowledgment:

Financial Consent:
We are committed to ensuring that our patients are informed of all costs prior to treatment with the dentist, therapist or hygienist. Our patient centered care is about eliminating the guesswork and making you feel as comfortable as possible. Payment is expected at the end of each appointment. While health insurance is designed to reduce your cost, it is important to note that it may not eliminate all fees entirely. We recommend that you check with your health insurance what your entitlements are before each appointment as they will vary depending on your level of cover and annual limits.

DON'T HAVE EXTRAS COVER? NO PROBLEM!
To assist with finance, we offer **Afterpay and Humm** payment plans, allowing you to break your expenses into "bite-sized" payments, helping you pay back costs over time. If you have any further queries about any of the payment plans, we offer, please ask our friendly staff.

Initial for Acknowledgment:

Cancellation Policy:
We understand that circumstances may change and you may be unable to attend your scheduled appointment. If this occurs, we ask that you provide us with as much notice as possible.

For cancellations made within 24 hours a $50 deposit may need to be taken before scheduling another appointment. This $50 deposit will be redeemable at your next visit. If you need to cancel within 24 hours again this deposit will be held for your next appointment.

Patients who make a booking and subsequently fail to present for their scheduled appointment (and have not contacted the practice to cancel their appointment) may also result in a cancelled booking fee being applied.

Initial for Acknowledgment:

Signed: Date: