PRISTINE DENTISTRY

New Patient

Medical and Dental History

Patient Details

Title: **O** Mr **O** Mrs **O** Ms **O** Miss **O** Mst **O** Dr **O** Other: _____

Surname: _____ *Given Name:* _____

Preferred Name: _____ *Language other than English*: _____

Residential Address: _____

Suburb: _____ *Post Code:* _____

Postal Address: _____

Phone Home: __ __ __ __ __ __ __ __ *Work:* __ __ __ __ __ __ __ __ *Mobile:* __ __ __ __ __ __ __ __ __ __

Email: _____

Occupation: _____ *Company:* _____

Emergency Contact: _____ *Relationship:* _____

Phone: __ __ __ __ __ __ __ __ __ __ *Aboriginal/Torres Strait Islander* ***O*** *Yes* ***O*** *No*

Private Health Insurer: _____ *Member #:* _____ *Patient #* _____

Medicare #: _____ *Ref #:* _____ *Expiry:* ___ / _____ *Vet Affairs#:* _____

GP Name: _____ *Phone:* _____

Medical History

Please tick if you have ever had any of the following:

O *Abnormal / Excessive Bleeding*	**O** *Cancer*	**O** *Kidney / Liver Disease*
O *Angina*	**O** *Cardiac Surgery/Pacemaker*	**O** *Neurological Disorder*
O *Anxiety / Depression*	**O** *Congenital Heart Defect*	**O** *Oral Ulceration*
O *Artificial Heart Valve*	**O** *Diabetes: Type 1 / Type 2*	**O** *Radiation / Chemotherapy*
O *Asthma*	**O** *Epilepsy*	**O** *Reflux*
O *Blood Disorder*	**O** *Hearing Impairment*	**O** *Rheumatic Fever*
Name:	**O** *Heart Disease*	**O** *Steroid Therapy*
O *Blood Pressure: High / Low*	**O** *Heart Murmur*	**O** *Stroke*
O *Blood Thinner*	**O** *Hepatitis A / B / C / D*	**O** *Thyroid Disorder*
O *Bone Disease e.g. Osteoporosis*	**O** *HIV Positive*	**O** *Other Conditions*
O *Bisphosphonate Therapy*	**O** *Immune Deficiency*	*1)*
Current / Past	**O** *Joint Replacement*	*2)*

Medical History (Continued)

Are you pregnant? **O** *Yes* **O** *No* *If yes, how many months?* _____

Are you Aboriginal or Torres Strait Islander? **O** *Yes* **O** *No*

List of Medications (including natural supplements): _____

_____

_____

Are you a smoker? **O** *No* **O** *Yes* *If yes, how often?* _____

Allergies:

O Aspirin **O** Iodine **O** Latex **O** Penicillin **O** Sulphur Drugs

O Other _____

Dental History

Last dental visit: _____ *Is there a particular reason for your visit today?* _____

_____

Have you ever had a reaction or complication following dental treatment in the past? **O** *Yes* **O** *No*

If yes, please detail: _____

Is there anything else the dentist, therapist or hygienist should be aware of? _____

Are you suffering from any of the following?

O *Bad Appearance of Teeth*	**O** *Discoloured Teeth*	**O** *Lost Filling/Cavity*	**O** *Toothache*
O *Bad Breath*	**O** *Dry Mouth*	**O** *Rapidly Decaying Teeth*	**O** *Unsatisfactory Denture*
O *Bleeding Gums*	**O** *Grinding / Clenching*	**O** *Pain: Face / Jaw*	**O** *Worn or Broken Teeth*
O *Clicking Jaw*	**O** *Missing Teeth*	**O** *Sensitive Teeth*	
O *Difficulty Chewing*	**O** *Loose Teeth*		

Have you ever had a sleep study and been diagnosed with sleep apnoea? **O** *Yes* **O** *No*

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) Therapy? **O** *Yes* **O** *No*

Has anyone ever told you than you snore? **O** *Yes* **O** *No*

After 6-7 hours of sleep do you wake up refreshed? **O** *Yes* **O** *No*

How did you find out about us?

O *Google* **O** *Our Website* **O** *Referred by whom :* _____

O *Flyer* **O** *Drive By:* **O** *Other:* _____

Privacy Policy and Signature

All personal information collected by Pristine Dentistry is strictly confidential and handled in accordance with our privacy policy.

By signing this form you hereby agree and acknowledge that: i) you have accurately completed this new patient medical history form to the best of your knowledge; ii) you consent to any treatment agreed upon, to be carried out by the dentist and their staff; iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependants; iv) payment is due at the time of service unless other arrangements have been made; and v) your dentist and/or staff may take images of your teeth both before and after treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Patient/Legal Guardian Name: _____

Signature: _____ *Date:* _____ / _____ / _____

Financial

Consent Form

Thank you for choosing Pristine Dentistry to care for your oral health. We are committed to ensuring that our patients are informed of all costs prior to treatment with the dentist, therapist, and or hygienist.

What You Need To Know Before Your Appointment

Our patient-centred care is about eliminating guesswork and making you feel as comfortable as possible. 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.

If you are a Bupa, Medibank Private, HCF, NIB or Smile.com Member

As a preferred dental provider clinic, we charge the preferred member fees. This ensures members enjoy certainty out-of-pocket costs^. **Payment for any out-of-pocket costs are due in full for each visit at the time of service,** unless another arrangement has been made prior to your appointment.

^Subject to insurance policy rules, waiting periods and yearly maximums are on most services.

If you're not a Bupa, Medibank Private, HCF, NIB or Smile.com Member

If you have extras cover with another health fund, you'll still be eligible for similar benefits, depending on your entitlements, level of cover, and yearly limits. Still, its always best to contact your health insurance company directly to confirm the details of your cover.

Don't have extras cover? No Problem!

To assist with finance, we offer National Dental Plan, Afterpay and Zip 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.

Please note we accept payment by Visa, Mastercard and Cash.

Signature

If you don't have any further questions and are happy to proceed with your treatment today, then please read, sign and date below:

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

Patient/Legal Guardian Name: _____

Signature: _____ Date: _____ / _____ / _____

Cancellation Policy

Policy Details

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.

We have a 24-hour cancellation policy. Any cancellations that occur 24 hours or more before your scheduled appointment time, are able to be re-booked at no additional cost to the patient.

Any cancellations by/for the patient that occur within the 24-hour period may result in a cancelled booking fee being applied.

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.

The cancelled booking fee is $25.00 and will be applied to your account for payment at your next appointment.

Our practice wants to be available for the needs of all our patients. By adhering to this policy, we are able to open otherwise unused appointments to better serve the needs of all patients.

Thank you for cooperation and being a valued patient of our practice.

Patient/Legal Guardian Name: _____

Signature: _____

Date: _____ / _____ / _____

Deposit Policy

Policy Details

At the time of booking your next appointment you may be asked to make a deposit. This is to both secure your appointment and enable us to prepare for your appointment effectively. This deposit will be taken off the cost of your appointment at completion.

Appointments that may require a $25.00 deposit include:

- New Patient appointments booked more than 5 business days in advance
- Appointments that are made in high demand times such as Saturdays and evening appointments, to ensure availability for everyone
- Any appointment that is requiring to be rescheduled within 24 hours of its intended time

A $300.00 deposit will be required for all new dentures

Patients who make a booking and subsequently fail to present for their scheduled appointment (and have not contacted the practice to cancel their appointment) or give less than 24 hours' notice of cancellation, may result in the deposit being retained by the practice.

Our practice wants to meet the needs of all our patients. By adhering to this policy, we are able to ensure great standards of care to better serve the needs of all patients.

Thank you for your cooperation and being a valued patient of our practice.

Patient/Legal Guardian Name: _____

Signature: _____

Date: _____ / _____ / _____