Have any of your details changed?

We value your privacy, all details will be kept strictly confidential.

**PERSONAL DETAILS**

**Have any of your personal details changed? YES / NO**

First Name:………………………………………………………… Surname:………………………………………………….

Address:…………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………... Post Code:………………………

Mobile Phone:……………………………………………. Home Phone:…………………………………………………..

Occupation: …………………………………………… Work Phone (In emergencies only)……………………………….

Email: …………………………………………………………………………………………………………………………

Emergency Contact Name: ……………………………………………………………

Contact No: ……………………………………………… Relationship to you: ……………………………………………...

Do you have any private health insurance? YES / NO (If yes, please specify below)

Health fund name:………………………………………… Member number: (eg, 01)…………

**MEDICAL DETAILS**

**Have any of your medical details changed? YES / NO**

Please Specify: ……………………………………………………………………………………………………………………………………………………………..

Ladies, are you pregnant? If so, how many weeks? ...............................

**Would you like to discuss or find out more information about any of the following:** (please circle)

Replacement of missing teeth Cosmetic appearance Removal of wisdom teeth

Teeth whitening Bad breath Bleeding gums Tooth grinding / Clenching

Replacement of silver (mercury) fillings Dentures Implants

**CONSENT**

• I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable and I will assume responsibility for the fees associated with those procedures.

• I understand diagnostic tools such as x-rays, photographs and study models may be required prior to the commencement of certain dental procedures.

• I am aware that full payment is required on the day of treatment.

• I acknowledge that the information given on this form is true and accurate to the best of my knowledge. It is my responsibility to inform the dentist of any changes in my medical status.

• I consent to health professionals who have treated me exchanging information about me as required via phone, mail or email to assist in providing oral health care to me.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_