Manchester Rd Dental Services Trust
ABN 807 307 49 557

Manchester Rd
DENTAL SURGERY

Dr. David Rivadillo
BDSc Hons (Melb) Provider 4345724B
Dr. Amanda Ho
BDSc (Melb) Provider 4226999Y
& Associates

Dear valued client,

Welcome to our practice. Please take your time to answer the following questions as carefully and thoroughly as possible. It will greatly assist us in providing you optimal care. All information will be treated with complete professional confidentiality. Thank you for your assistance.

PATIENT DETAILS

Title : Mr / Mrs / Ms / Miss / Master / Dr Surname: .....

Given names: .....

Date of birth: ..... Home phone: ..... Mobile: .....

Home address: ..... Suburb: ..... P/Code: .....

Email: .....

Postal address (if different to above): .....

Person responsible for fees: .....

Emergency contact: ..... Relationship: .....

Address: ..... P/Code: ..... Ph: .....

Medical doctor and practice name: ..... Ph: .....

Who recommended this practice to you? .....

DENTAL HISTORY

Do you have dental insurance? YES/NO Which fund? .....

Are you concerned about any of the following regarding your teeth?

☐ Currently causing pain ☐ Wear ☐ Shape ☐ Position ☐ Colour

Do you require treatment under Nitrous gas (happy gas)? YES / NO

⇨ ⇨ ⇨ **PLEASE TURN OVER TO COMPLETE MEDICAL INFORMATION** ⇨ ⇨ ⇨

MEDICAL HISTORY

Have you ever had any of the following? Please indicate by TICKING YES or NO:

	YES	NO		YES	NO
High blood pressure	☐	☐	Diabetes	☐	☐
Heart problems	☐	☐	Thyroid problems	☐	☐
Rheumatic fever	☐	☐	Excessive bleeding or blood disorder	☐	☐
Asthma, chest, or breathing problems	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
Gastric reflux	☐	☐	AIDS/HIV	☐	☐
Kidney disease	☐	☐	Bone disorders incl. osteoporosis	☐	☐
Radiation therapy for cancer	☐	☐	Anxiety/psychology/mental health	☐	☐

If you have a heart problem, please circle if it is: angina / a pacemaker / a stent / heart valve problem previous infective endocarditis / other: .....

Do you have an artificial heart valve, hip, or other prosthetic implant? .....

Do you smoke or vape? **YES** ☐ **NO** ☐ If yes, how many or how often each day?.....

Female patients, is there the possibility you may be pregnant? If so, how many weeks? .....

Any other medical history your dentist should be made aware of? .....

MEDICATIONS

There are many medications that may impact your oral health or treatment we plan for you. Please indicate by TICKING and LISTING, any medications that you are currently taking or have taken recently.

☐ Cancer medication ..... ☐ Corticosteroids .....

☐ Heart or blood pressure medication ..... ☐ Diabetes medication .....

☐ Blood thinners *e.g. Warfarin, Plavix, Aspirin, Coumadin* .....

☐ Bisphosphonates *e.g. Didronel, Bonefos, Fosamax, Alendro, Actonel, Skelid, Aredia, Pamisol, Zometa* .....

Other medications, please list: .....

ALLERGIES & ADVERSE REACTIONS

Do you have any allergies? If yes, please state allergy and its affect on you .....

I have completed the questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I give permission for the practice to use the above contact details to send me appointment and recall reminders.

☐ I give permission for the practice to use anonymous photos of my teeth for marketing purposes

☐ I would like to receive the practice newsletter by email, covering tips for oral health and practice updates

Patient/guardian/carer signature ..... **Date** .....

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Welcome to Manchester Rd Dental Surgery!

We would appreciate a minute of your time to read the following. Please read our terms and conditions and sign and date the agreement.

BOOKING FEE POLICY

Our practice is committed to providing comprehensive care to our patients. We do our best to accommodate our patient's busy schedules and provide care in a timely manner. To aid us in these directives, we ask that our patients notify us in advance if they must reschedule their appointments, so we are able to offer that appointment to other patients.

- We require our patients to notify us at least 24 hours in advance of their scheduled appointments if they are unable to attend. For appointments over 60 minutes in length, we require patients to notify us of any changes at least 48 hours before their appointment.
- If a patient fails to notify us within the specified time period, we reserve the right to require a deposit before scheduling future appointments. This deposit will be either put towards the next visit or will be kept as a booking fee, if the patient is unable to notify us within the specified time again.

I, _____ , have read and agree to our booking fee policy.

Patient/Parent/Guardian signature: _____ Date: _____

How did you hear about Manchester Rd Dental Surgery?

- O Google
- O Driving Past
- O Facebook
- O Instagram
- O Word Of Mouth Online (WOMO)
- O Current or Past Patient: _____(patient's name)
- O Other: _____ (please specify)