CBRProsthodontics

specialist dental æsthetics and function

Please email or bring this form with you. We look forward to welcoming you to Canberra Prosthodontics.

Full Name: _____

Date of Birth: _____

Street Address: _____

Suburb: _____Post Code: _____

Postal Address: _____

Telephone Number: Home_____ Work_____ Mobile_____

Email Address_____

Next of kin _____ Contact details_____

For children under 18 years of age, the name of your parent or guardian:

_____

Are you the person responsible for the payment of accounts? Yes No

If not, which organization is responsible for paying accounts for your treatment: Department of

Veterans' Affairs DVA Number:_____

Defence PMKEYS Number: _____

Insurance Company Claim Number: _____

Other _____

Is your treatment related to an injury that is the subject of a legal claim?

Eg: a motor vehicle accident claim? _____

Referral source:

Website Dentist Name:_____ Other:_____

Patient History

Accurate information regarding your medical history and previous dental experience is important in ensuring that you receive the best treatment possible. To assist us in this important area, please answer the following questions as accurately as possible. If you are unsure of anything please ask one of us.

Please circle if you have ever had or do have any of the following conditions

Heart:

Rheumatic Fever
Low Blood Pressure
Pacemaker Fitted
Thrombosis
High Blood Pressure
Heart Surgery
Heart Murmur
Angina

Details: _____

Chest:

Bronchitis
Pneumonia
Smoker
Pleurisy
Emphysema
Chest Surgery
Cystic Fibrosis

Details: _____

Blood:

Prolonged Bleeding
HIV
Sickle Cell
Hepatitis A B C
Anaemia
Haemophila

Details: _____

Other:

Serious Childhood illness
Liver Disease
Epilepsy
Hiatus Hernia
Gastric Problems
Diabetes
Kidney Disease
Cancer
Arthritic Condition
Depressive Illness

Details: _____

Allergies:

Penicillin
Anti Tetanus Serum
Aspirin
Local Anaesthetic
Adrenalin
Hay Fever
Eczema
Asthma
General Anaesthetic
Latex

Other: _____

Any other medical issues not already mentioned: _____

Do you require Antibiotic cover prior to any invasive treatment? Yes No

Are you pregnant or think you might be? Yes No

General medical practitioner's details:

Name: _____ Contact Number: _____

Address: _____

Are you taking any drugs, pills or medications? Yes No

Please include all prescription medications, as well as herbal medications.

Medication	Dose	Duration

Have you received a blood transfusion or blood products in the last 5 years? Yes No

At Canberra Prosthodontics:

- We will deliver the highest quality dental care
- We will provide a safe environment within our practice
- We respect your culture, beliefs, values and characteristics
- We will endeavour to communicate to you all possible treatment options including advantages, risks, and approximate fees
- We encourage you to participate in decisions about your care
- We respect the privacy and confidentiality of you and your healthcare records
- We appreciate your feedback

For further information on your rights at Canberra Prosthodontics, please ask to see our patient's rights policy or a copy of The Australian Charter of Healthcare Rights.

At Canberra Prosthodontics we require payment for services **on the day of treatment**. Credit will not be extended without prior approval.

Any outstanding accounts over 90 days will be referred on to a collection agency, and any additional administrative fees will be added to the account.

I, _____, agree to the above conditions of treatment at Canberra Prosthodontics.

Signature:_____ **Date:**_____

Clinician Signature:_____ **Date:**_____