Are you covered by **Private Health**?

If so which Fund:……

Medicare Number:…… **Line No** (No next to name)……..

Who is responsible for account payments?.....

……

How would you like to receive reminders: SMS / Email / Phone

We request and expect payment at the time of treatment.
For your convenience we accept Cash/Cheque/Eftpos and all major credit cards.

Hicaps refunds are immediately available. For extensive treatments a number of payment options are available.

In the event of your account being over due and being referred to an external party for collection you shall be liable for all resulting costs arising from the recovery.

PLEASE NOTE: A CANCELLATION FEE WILL BE CHARGE IF 24 HOURS NOTICE IS NOT GIVEN.

Signature:……

Date:……../……../ 20….

MURRAYLANDS DENTAL CARE

CONFIDENTIAL PATIENT INFORMATION

Dr / Mr / Mrs / Ms / Miss / Master / Other- ***Please circle***

Surname:……

First:……

Date of Birth: ……../……./……..

Residential Address:……

……Postcode……

Postal Address ***(If different)***:……

……Postcode: ……..

Home Phone:……Work Phone:……..

Mobile Phone:……..

Email: ……

Occupation:……

In Case of Emergency :

Contact Name:……

Contact Number:……...

Relationship to you:……

When was your last dental visit?.....

CONFIDENTIAL MEDICAL HISTORY

Please Circle:

Smoker/ Non-Smoker

Pregnant/Breast Feeding (Currently)

Acquired Immune Deficiency Syndrome (AIDS)

Asthma	Epilepsy	Diabetes
Pacemaker	Depression	Stroke
Osteoporosis	Organ Transplant	Artificial Joints/Valves
Heart Ailments	Rheumatic Fever	Kidney Disease
Hepatitis A/B/C	Angina	Chemotherapy/Radiotherapy

Blood Pressure: Low/High

Any other medical conditions *(Please list)*:……

……

Are you currently receiving medical treatment? *(If so please list)*

……

……

Are you currently taking any Medications or Homeopathic Remedies

(Please List):……

……..

CONFIDENTIAL MEDICAL HISTORY continued;

LATEX allergy: YES / NO

Please list any allergies (Medications/Foods):……

……

……

Have you ever had an unfavorable reaction to local anaesthetics: YES / NO

Name of Medical Practitioner:

……..

Phone Number:…….

How did you hear about us? *Please Circle*

Internet	Newspaper Ad	White Pages
Walk / Drive By	Local Mag	

Dr's Referral (If so who?)……

Friend/Family (If so who?)……

Other: ……

P.T.O