Castle Cove FAMILY DENTAL

Level 1, 16e Deepwater Road
Castle Cove NSW 2069
ph. (02) 9417 7222
f. (02) 9417 7233
www.castlecovedental.com.au

ACQUAINTANCE FORM

Welcome to our practice! Please take your time to answer these questions as completely as possible.

It will assist us greatly in our effort to provide the best dental treatment for you.

☐ Ms ☐ Mrs ☐ Mr ☐ Miss ☐ Master ☐ They ☐ Other

Patient Name. _____ Birth Date. _____

Sex. ☐ Male ☐ Female ☐ Other Status. ☐ Married ☐ Single ☐ Child ☐ Other

Preferred Name. _____

Home Phone. _____ Work. _____ Mobile. _____

Email address. _____

Address. _____

_____ Occupation. _____

How did you find out about our practice? _____

Are you in a health fund? ☐ No ☐ Yes. If yes, which one? _____

Surname.

This section is essential to us in providing safe medical treatment.

Do you have any of the following? (Please tick)

☐ Codeine Allergy	☐ Asthma	☐ Healing Complications	☐ Heart Murmur
☐ Penicillin Allergy	☐ Cancer	☐ Excessive Bleeding	☐ Other Allergies. _____
☐ Depression/Anxiety	☐ Diabetes	☐ Recurrent Headaches	☐ High Blood Pressure
☐ Hepatitis: Type. _____	☐ Dizziness	☐ Radiation Treatment	☐ Kidney Disease
☐ Anaemia	☐ Epilepsy	☐ Respiratory Problems	☐ Liver Disease
☐ Arthritis	☐ Fainting	☐ Tuberculosis	☐ Hay Fever
☐ Artificial Joints	☐ HIV	☐ Rheumatic Fever	☐ Other. _____
☐ Osteoporosis			

Are you or could you be pregnant? ☐ Yes ☐ No

Do you smoke / e-cigarettes / vape? ☐ Yes ☐ No

Are you currently taking any medications or other drugs? ☐ Yes ☐ No

If yes, please state. _____

Name of your General Practitioner? _____ Phone. _____

Have you been hospitalised in the last 2 years? _____

If yes, please explain. _____

When was your last dental appointment? _____

Would you like us to discuss tooth whitening with you? ☐ Yes ☐ No

Are you concerned about or experiencing any of the following dental problems? (Please tick)

☐ Sensitivity to hot or cold	☐ Staining of your teeth	☐ Clicking/pain in the jaw joints	☐ Roughness of existing fillings
☐ Food trapping between your teeth	☐ Discoloured fillings	☐ Bleeding gums	☐ Sensitivity when eating
☐ Grinding or clenching of your teeth	☐ Head/neck ache	☐ Bad breath	

Are you concerned with: (Please tick)

☐ Existing crowns, bridges or dentures	☐ Ability to eat	☐ Gaps between your teeth	☐ Tooth clean techniques
☐ Discolouration of your teeth	☐ Your smile	☐ Crooked teeth	☐ Previous dental treatment
☐ Missing teeth	☐ Silver fillings		

Date. ☐☐/☐☐/☐☐☐☐

Please turn over

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Responsible Party Information

The following information is for the person responsible for Payment.

Relationship to patient. ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other

If the responsible party is other than self, please complete the following.

Otherwise, please refer to the next section.

Name. _____ Birth Date. _____

Sex. ☐ Male ☐ Female

Home Phone. _____ Work. _____ Mobile. _____

Address. _____

_____ Occupation. _____

Consent for Services

This practice depends upon reimbursement from our patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As a condition of your treatment by this office, financial arrangements must be made in advance.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. There is no relationship between the doctor and the health fund. Any relationship with an insurance company is between the patient and their health fund.

Payment for services is expected on the day that treatment is rendered. A service charge of 10% on the unpaid balance will be charged on all accounts exceeding 30 days unless previously written financial arrangements are satisfied. I understand that a bookkeeping fee may also be charged to my account.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I understand that all health information given will be treated with privacy and confidentiality.

I have read the above conditions of treatment and agree to their content.

Signature. _____ Date. _____

Please save this form using your name as the title, and email to info@castlecovedental.com.au