nib dentalcare centre

Health Record Update

Title Dr / Mr / Mrs / Miss / Ms / Other

Surname ______________________________ First name ____________________ Date of birth ___/___/ _____

Medical / Dental History Update

Since your last visit (or in the past 12 months), have you experienced any of the following:

A change in your overall health? YES / NO Details ____

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A change in Blood Pressure? YES / NO Details ____

A recently diagnosed illness or medical condition? YES / NO Details ______________________________

A change in bone density / diagnosed osteoporosis? YES / NO Details ______________________________

A change in HIV/Hepatitis status? YES / NO Details ____

The need for hospitalisation? YES / NO Details ____

A change in Medication? YES / NO Details ____

Recently diagnosed allergies? YES / NO Details ____

Any Dental Concerns? YES / NO Details ____

Personal Details

Have your personal details changed? YES / NO - If yes, please complete the relevant changes below

Home address ____

____ Postcode ____________

Postal address ____ Postcode ____________

Phone (Mob) ____________________ (Hm) ____________________ (Wk) ____________________

Email ____

Health fund for dental cover __________ Membership No. ____________ Patient ID. ______________

Medicare Card No. ______________ Patient ID. ___________ Vet Affairs Card No. ______________

Emergency contact ______________ Relationship to patient _______ Contact No. ______________

Medical Practitioner ______________________________ Contact No. ______________________

Person responsible for account (must be completed if patient under 16, if same as above please tick here ☐)

Name ________________________ Relationship to patient __________________________________

Address ____ Postcode ____________

Phone (Mob) ____________________ (Hm) ____________________ (Wk) ____________________

If third party, insurance company/employer responsible for account ______________________________

I agree that the above is a true and accurate record. I understand that this Pacific Smiles Dental centre requires payment on the day of treatment. Any expenses, costs or disbursements incurred by the Pacific Smiles Dental centre in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a non-refundable deposit requirement prior to future appointments being scheduled. I have read and agree with the privacy statement provided to me.

PLEASE NOTE: This form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

✗ Signature ____ Date ____ / ____ / ______