Melton Dental Group

A Paramount Dentist

WELCOME TO THE MELTON DENTAL GROUP

At Melton Dental Group, we aim to provide you with quality dental care. Personal information including your past and present medical health is required for your dentist to provide you with safe and appropriate dental treatment.

Any information on your dental file, including information on this form, will not be disclosed to any person not involved without your prior written consent. Records are strictly confidential under the Privacy Act 1988. If you would like more information about our privacy policy, a brochure is available upon request.

Title: **First Name:**	**Surname:**
Preferred Name:	**Date of Birth:**
Address:	**Suburb/Town:** **Post Code:**
Mobile:	**Home Phone:**
Work Phone:	**Preferred method of Maintenance reminder:** ☐ SMS ☐ Letter ☐ Email
Email:	

How did you find out about us?

☐ Google ☐ Local Community ☐ Clinic Website ☐ Passing By
☐ Advertisement ☐ Specialist referral ☐ Yellow Pages ☐ Facebook
☐ Referred by a friend/family Full name of referrer (if applicable):

Emergency Contact Name:	**Emergency Contact Number:**
Private Health Insurance Fund:	**Membership Number:** Reference (number next to patient's name):
Medicare Number:	**Reference** (number next to patient's name):
Person responsible for fees:	

Please Note: Please be aware that all accounts are to be paid on the day of treatment.

Appointment cancellations require at least 24 hours' notice. If insufficient time is given, you may be required to pay a $75 deposit to rebook your appointment. This deposit will be deducted from your total account on your next treatment date.

Appointment confirmations are completed 48 hours prior to your appointment, if we have not received contact by 24 hours prior, we will attempt to contact you again. If we have not received confirmation by the morning of your appointment, that appointment time may be taken for another patient, and you will be required to reschedule.

PTO for medical history information

Medical History – To the best of your knowledge, do you have, or have you ever suffered from the following?

☐ High Blood Pressure	☐ Heart Disease	☐ Hepatitis ___________________
☐ Low Blood Pressure	☐ Respiratory/Lung Disease	☐ Infectious Disease (e.g. HIV/STD/MRSA)
☐ Stroke	☐ Rheumatic Fever	
☐ High Cholesterol	☐ Excessive Bleeding	☐ Diabetes
☐ Arthritis	☐ Osteoporosis	☐ Other
☐ Anxiety	☐ A.D.D or A.D.H.D	____________________________
☐ Autism	☐ Immunity Problems	☐ None of the above

Do you smoke? ☐ Yes ☐ No | **How many per day?**

Do you drink alcohol?

☐ Never	☐ Occasionally	☐ Weekly
☐ Rarely	☐ Daily	☐ Monthly

Allergies – To the best of your knowledge, do you have any allergies or reactions?
If **YES,** please list:

Are you pregnant? ☐ Yes ☐ No | **Due Date:**

Are you currently taking any medication for the following? If YES, please list:

☐ Anti-inflammatory ___________________________	☐ Cancer Medication ______________________________
☐ Painkillers___________________________________	☐ Cancer Therapy_________________________________
☐ Antibiotics ___________________________________	☐ Contraceptive Pill ______________________________
☐ Bisphosphonates or any medication that affects bone growth or metabolism__________________	☐ Asthma Inhaler/Medication _____________________
	☐ Blood Thinners _________________________________

☐ Heart or Blood Pressure Medication ____

☐ Other____	☐ None of the above

How long has it been since your last dental examination?

Do you have any of the following dental concerns?

☐ Toothache	☐ Sensitive Teeth	☐ Bleeding Gums
☐ Bad Breath	☐ Dry Mouth	☐ Broken, Loose or Missing Teeth
☐ Discoloured Teeth	☐ Grinding/Clenching	☐ None of the above

By signing this form, I am stating that the information provided is accurate to the best of my knowledge. I hereby authorise for any treatment agreed upon by me, to be carried out by my dentist and their staff. I have acknowledged payment, cancellation and confirmation policies, listed on the first page and understand the consequences of these.

Patient Signature: **Date: ………/………/………**

(Parent/Guardian must sign for persons under 18)