Dr Kenny Lee, BDSc (Melb) Dental Surgeon 2639004A
Dr Kai Xu, BDSc (Melb) Dental Surgeon 2616063L
Dr Sobiya Pathmalinkam, B Dent (Syd) Dental Surgeon 4368525J
Yvette Ding, BOH (Melb) Oral Health Therapist

PATIENT DETAILS & MEDICAL HISTORY

(MR / MRS / MS / MISS / MST / DR)

NAME: _____ DOB:_____

ADDRESS: _____

PHONE: H: _____ W:_____ M:_____

EMAIL: _____ OCCUPATION: _____

PERSON RESPONSIBLE FOR FEES: _____ PRIVATE HEALTH INSURANCE (DENTAL): _____

EMERG CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

MEDICAL DOCTOR: _ _____PH NO:_____

WHO REFERRED YOU TO OUR PRACTICE? ☐ Personal ☐ Signage ☐ Google ☐ Facebook/Instagram

Have you had any of the following? (Please Tick)

Heart Problems or Circulatory Problems	☐	Blood Pressure	☐	Artificial Joints	☐	Tumour History	☐
Liver or Kidney Problems	☐	Asthma	☐	Epilepsy	☐	Ulcers (stomach)	☐
Blood Disorders or Anaemia	☐	Diabetes	☐	HIV	☐	Hepatitis **A B C D E**	☐
Excessive bleeding or Bruising	☐	Sinus Trouble	☐				

Do you Smoke? Y N **Female Patients: Are you pregnant? Y N**

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Do your gums bleed? ☐ How many times a day do you brush? _____

Have you ever had problems with previous dental treatment? ☐ Please explain:_____

How long has it been since your last dental visit? _____

Are you allergic to any of the following? Latex ☐ Penicillin ☐ Codeine ☐ Others:_____

Are you currently taking any drugs or medicines? ☐ Please list:_____

Have you ever taken medication for bone cancer or Osteoporosis? ☐ Please list:_____

Is there anything else you would like to discuss with us? _____

CONSENT FOR TREATMENT

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make thorough diagnosis.
2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetics agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.
5. Any treatment recommendations are made on what is best for you, our patient: treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay.
6. All information will be held in confidence according the Privacy Act 1988.
7. Do you allow Sparkle Dental Care to contact you by e-mail for further correspondence informing clinic updates and promotions?

Patient/Parent Signature:

_____**Date:**_____