sparkle DENTAL CARE

Provider Numbers:
Dr Kenny Lee, BDSc (Melb) Dental Surgeon 2639005K
Dr Kai Xu, BDSc (Melb) Dental Surgeon 2616066Y
Ms Denise Galuoppo, RDH (Indiana) Dental Hygienist

Surname: …… Title: Mr/Mrs/Ms/Miss/Dr……

Given Names: …… Date Of Birth: ……

Home Address: …… P/Code: ……

Ph: …… Mobile: …… BH: ……

Business Address: ……

Email: …… Fax: ……

Postal Address (If different to above) ……

Occupation: ……

Emergency Contact (Name, Contact Number and address) ……

Medical Doctor: (Name, Contact Number and address) ……

Who referred you to our practice?……

Do you have dental insurance? Which fund? ……

Membership No……

Patient No……

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE:

	Yes	No		Yes	No
Heart Ailment……	☐	☐	Thyroid Problems……	☐	☐
Heart Valve Disease……	☐	☐	Osteoporosis……	☐	☐
High Blood Pressure……	☐	☐	Diabetes……	☐	☐
Rheumatic Fever……	☐	☐	Excessive Bleeding/Blood Disorder……	☐	☐
Asthma, Chest/Breathing Problems….	☐	☐	Epilepsy……	☐	☐
Tuberculosis……	☐	☐	Hepatitis……	☐	☐
Stomach or Bowel Problems……	☐	☐	Kidney Disease……	☐	☐
Do you smoke?……	☐	☐	HIV……	☐	☐

List any other previous illnesses:……

Do you have: an artificial hip, heart valve or any other prosthetic implant?……	☐	☐
Have you ever had problems with dental treatment?……	☐	☐
Have you ever taken medication for bone cancer or osteoporosis ?……	☐	☐
Female patients, are you pregnant?……	☐	☐

Do you have any allergies? (E.g. Penicillin, Latex)……

Please list all medication you are taking……

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE

CONSENT FOR TREATMENT

1. I hereby authorize the dentist or designated staff to take x-ray, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnostic assessment.
2. Upon such diagnostic assessment, I authorize 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 anaesthetic agents embodies certain risks. I understand I can ask complete recital of any possible complications.
4. I agree to be responsible for payment of all services unless other arrangements have been made.
5. I acknowledge that Sparkle Dental Care Bayside has a 48 hour cancellation policy. I will endeavour to provide two business days notice should I not be able to attend an appointment. I also acknowledge that if I miss a scheduled visit, there may be cancellation fee involved.

Signed…… Date……

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED.