RIVERSIDE
dental spa

Welcome to Riverside Dental Spa. In order to provide you with complete quality care we need to know about your state of health & medical history. In accordance with the Privacy Amendment Act 2004 & the Health Records & Information Act 2002, all information provided will be treated in strictest confidence & available only to third parties you have consented to. Please complete accurately.

Personal Information

Title: Dr/Mr/Master/Mrs/Miss/Ms
Surname:_____ First name:_____

D.O.B:_____/_____/_____ Email:_____

Address:_____Post code:_____

Phone (H):_____(W):_____(M):_____

Occupation: _____Company:_____

Emergency contact:_____Relationship:_____Phone:_____

Health Fund:_____ Membership #:_____Ref #:_____
Medicare #:_____Ref #:_____ DVA #:_____

(Reference number refers to the allocated number next to your name)

Medical History Information

Are you taking any medications? □ No □Yes, please list: _____

Allergies: □ No □ Yes _____

Conditions

□ Anaemia
□ Arthritis
□ Asthma
□ Haemophilia/Prolonged Bleeding
□ Cancer
□ Chemotherapy
□ Kidneys/Liver
□ Epilepsy
□ Heart Conditions
□ Radiotherapy
□ Rheumatic Fever
□ Smoker
□ Stroke
□ Indigestion
□ HIV/AIDS
□ Hepatitis
□High/Low Blood Pressure
□ Joint Replacement Surgery
□ Diabetes
□ Pregnant
□ Osteoporosis

If you have ticked yes to any of the above please specify relevant details:

_____

_____

Person responsible for paying account if patient is under 18 years of age
Name:_____ Relationship to patient:_____ Phone:_____

I agree that the above information is a true and accurate record. I understand that Riverside Dental Spa requires **payment on the day of treatment**. Any expense or cost incurred by Riverside Dental Spa in recovering any outstanding monies including debt collection fee and legal cost shall be paid by the responsible party above. I further acknowledge that **failure to attend** any appointment without **48 hours' notice** may result in a cancellation fee or a deposit being required to future appointments.

Patient Signature:_____ Date: _____

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