CONFIDENTIAL PATIENT RECORD

TITLE:	
SURNAME:	
FIRST NAME:	
OTHER NAMES:	
BIRTHDATE:	
ADDRESS:	
SUBURB:	
POSTCODE:	
HOME PHONE:	
WORK PHONE:	
MOBILE:	
EMAIL:	
HEALTH FUND:	
HEALTH FUND #:	Patient Seq #
DRIVER'S LICENCE #:	
OCCUPATION:	
NEXT OF KIN & CONTACT NUMBER:	

Payment and Cancellation Policy

Our standard policy is that payment of your account is due and payable on the day of your treatment. In certain cases a deposit may be required prior to the There is a nominal $25 fee per 30 minutes of scheduled time for a missed appointment or cancellation with less than 24 hours' notice during office hours. If our staff is successful in rebooking your appointment time with another patient, the cancellation fee will be waived.

Any expenses incurred by Aria Dental in recovering outstanding monies including debt collection agency fees and solicitors' costs shall be paid by the client.

APPOINTMENT CONFIRMATION: (please tick)
Phone: ☐
SMS: ☐
Email: ☐

HOW WERE YOU REFERRED TO THIS PRACTICE?

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Please indicate whether the following apply to your medical history

	YES	NO
Asthma	☐	☐
Blood Disorders or Bleeding Problems	☐	☐
High Blood Pressure	☐	☐
Cardiac Pacemaker or Valve Replacement	☐	☐
Chemotherapy or Radiation Therapies	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Gastric Problems / Ulcer	☐	☐
Heart Complaint	☐	☐
Hepatitis or Liver Disease	☐	☐
HIV / AIDS	☐	☐
Joint / Other Prosthesis	☐	☐
Kidney Problems / Transplant	☐	☐
Nervous System Disorder	☐	☐
Respiratory Problems	☐	☐
Rheumatoid / Auto-immune Problems	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Other*	☐	☐

*Please Specify:_____

Name of your **DOCTOR / MEDICAL** Centre:

Please list any **MEDICATIONS / TABLETS** you are taking:

Please list any known **ALLERGIES**:

	YES	NO
Are you a smoker or ex-smoker?	☐	☐
Females – Are you currently pregnant?	☐	☐
Are you presently receiving any medical treatment?	☐	☐
Would you like to rate us? If so, we will send you a link via email, Thank you ☺	☐	☐

PATIENT MEDICAL RECORD

Signature: _____ Date: / /