BROADWAY dental™
for a smile to remember™

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Pre-Treatment Details for Broadway Dental Centre™

Welcome to our practice. We look forward to giving you the best service possible so you can enjoy the benefits of dental health. A good smile, even bite, healthy gums and reduced dental decay all result from modern dentistry. You will find everyone here friendly and helpful.

To give you the very best care safely it is essential for us to have details of your medical history and any medication you may be having that could cause you problems during dental treatment. Please fill in the details as accurately as you can and ask for any help you may need to understand and fill in correctly.

NAME IN FULL Mrs, Miss, Ms, Mr ______

ADDRESS (No PO BOX numbers please) ______ POST CODE ______

PHONE: HOME ______ WORK ______ MOBILE ______

PLACE OF WORK ______ FAX ______ EMAIL ______

OCCUPATION ______ **DATE OF BIRTH** ______

DO YOU BELONG TO A HEALTH FUND? YES / NO **IF 'YES'** WHICH ONE? ______

HOW DID YOU FIND OUT ABOUT US? (Please Tick One)

☐ Referred by a Friend ☐ Search Engine ☐ Street Sign ☐ Glebe Paper ☐ Website ☐ 10 Years Younger in 10 Days program ☐ Other: ______

Is there something about your smile that you are not happy with? ______

WHO WILL BE RESPONSIBLE FOR PAYMENT OF TREATMENT? ______

ADDRESS ______ POST CODE ______ PH ______

TO HELP US HELP YOU, PLEASE ANSWER THESE GENERAL HEALTH QUESTIONS:

Has there been any serious health problems recently? YES / NO If 'YES' please describe ______

Have you ever had an adverse reaction to any medicine or other substance? YES / NO If 'YES' please describe ______

What drugs or medicine are taken on a regular basis? ______

Ladies, please state if there is any possibility of pregnancy. YES / NO

ARE ANY OF THE FOLLOWING PRESENT? (please tick correct response)

Heart or blood vessel disease	YES / NO	Artificial heart valves, pacemaker	YES / NO	Asthma, diabetes, Rheumatic fever	YES / NO
Blood pressure problems	YES / NO	Blood disease, bleeding problems	YES / NO	Liver, Lung, Kidney disease	YES / NO
Other health problems, disabilities	YES / NO	**If 'YES'** please describe ______			

NAME OF MEDICAL DOCTOR ______ **PHONE** ______ **FAX** ______

NAME OF SURGERY ______ **ADDRESS** ______

IN CASE OF AN EMERGENCY, WHO WOULD BE YOUR NEXT OF KIN?

NAME ______ ADDRESS ______

HOME PHONE ______ WORK PHONE ______ MOBILE ______

PLEASE READ THIS SECTION VERY CAREFULLY

Do you think you may be in a High Risk Category? (ie Hep A,B or C,HIV+) YES / NO If so please discuss this with the Doctor that you will be seeing.

REMEMBER , ALL INFORMATION IS TREATED WITH COMPLETE PROFESSIONAL CONFIDENTIALITY!

I certify that the above information is true and correct. In accordance with the Privacy Act (1988) I authorize any person or company to give information as may be required in response to credit inquiries. I have read and understood the GENERAL TERMS AND CONDITIONS OF TRADE (OVERLEAF) of Broadway Dental Centre which form part of and are intended to be read in conjunction with my Tax Invoice and agree to be bound by these conditions.

Signed: ______ Date: ____/____/____

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