Herald Avenue
DENTAL CENTRE

CONFIDENTIAL PATIENT QUESTIONNAIRE

Name: _____
Surname First Names Dr / Mr / Mrs / Miss / Ms

Preferred Name: _____ Health Fund: _____

Home Address: _____ Home Phone: _____

City/Suburb: _____ Mobile Phone: _____

Post Code: _____ Occupation: _____

Date of Birth: _____ Email Address: _____

Next of Kin/Emergency Contact Details:

Name: _____ Phone Number: _____Relationship:_____

Are you happy with your smile? Yes/No
If no, what don't you like about it? _____

Would you like to receive promotional offers from Herald Avenue Dental? Y/N

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes/No
   If so, please provide details; _____
2. Have you experienced any allergies or adverse effects from any medication, materials and anaesthetic? Yes / No
   If so, please provide details; _____
3. Does any of the following apply to you? If so, please tick as appropriate;

☐ Rheumatic Fever	☐ Epilepsy	☐ Hepatitis B or C
☐ Heart Trouble	☐ Prosthetic joint	☐ HIV/AIDS
☐ High Blood Pressure	☐ Diabetes (Type 1 or 2)	☐ Depression/Anxiety/Other
☐ Asthma	☐ Liver or Kidney Disease	☐ Osteoporosis
☐ Chemotherapy or Radiotherapy	☐ Smoker	

   Details: _____
4. Are you taking any medications? If yes please specify:
   _____
   _____
5. Are you pregnant? Yes/No If so, how many months: _____

DENTAL HISTORY

1. When was your last visit to see a dentist? _____
2. Are you experiencing any dental pain/problems at present? _____

Preferred contact Method?(Please circle) Text Message / Phone Call / Email

How did you hear about us?

☐ Doctors Surgery	☐ Health Engine	☐ Facebook
☐ Street Sign	☐ Google search	☐ Another patient/friend (Name) _____
☐ Flyer	☐ Sports Club	☐ Other _____

Signed: Patient/Parent/Guardian _____ Date: _____

PLEASE TURN OVER

Herald Avenue
DENTAL CENTRE

Cancellation Policy

We respectfully ask for a minimum of 24hrs notice if you are unable to attend your appointment. We reserve all appointment times exclusively for patients, dedicating our resources to that person for that time.

We pride ourselves on keeping our costs affordable for patients. One way we do that is the efficient use of equipment, professional staff and appointment times. Missed and/or last-minute cancellations result in wasted clinical time and cause other patients to miss out.

Any missed appointments or **cancellations with less than 24hrs notice will result in a cancellation charge of $50 per 30mins of your scheduled appointment.**
Please note however, if you need to cancel your appointment within 24hrs due to illness or an extenuating circumstance we may take this into consideration.

Appointments on Saturdays are at no extra cost to our patients. However, as they are in high demand, **any cancellations within 24hrs of Saturday appointments will incur a $50 charge per 30mins of your scheduled appointment.**

_____ _____

Patient's name (Please print) Signature of Patient/Legal Guardian

_____

Herald Ave Dental Representative

Date: _____