CONFIDENTIAL PATIENT RECORD

Aria DENTAL
ZANINOVICH & ASSOCIATES

PATIENT RECORD

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

APPOINTMENT CONFIRMATION:
(please tick)

PHONE: ☐
SMS: ☐
EMAIL: ☐

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Please indicate whether the following apply to your medical history

	Y	N
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:		

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 your appointment. 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 may 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.

Extended Consultations

Voice recordings of consultations may be taken to assist in planning your dental care. The recording will be kept as part of your confidential patient record and will not be disclosed without your consent. Please inform your dentist if you wish not to be recorded.

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

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

Please list any known **ALLERGIES**:

	Y	N
Are you a smoker or ex-smoker?	☐	☐
Females – Are you currently pregnant?	☐	☐
Do you give Aria Dental permission to use your photographs for educational & training purposes?	☐	☐
Would you like to rate us? If so, we will send you a link via email, Thank you!	☐	☐

PLEASE TURN OVER

EXTENDED MEDICAL QUESTIONNAIRE

	Y	N
Are you currently having dental pain?	☐	☐
Do your gums bleed when you brush your teeth?	☐	☐
Do you grind your teeth during the night or clench your teeth during the day?	☐	☐
Do you suffer from clicking jaw joints, sore facial muscles, frequent headaches, ear aches or pain whilst chewing?	☐	☐
Have you ever been instructed on proper oral hygiene for your teeth and gums?	☐	☐
Have you ever had periodontal, gum (pyorrhoea) treatment?	☐	☐
Do you have any sores or lumps in your mouth?	☐	☐
Do you ever experience bad breath or any bad tastes in your mouth?	☐	☐
Do you have sensitive teeth to hot, cold or sweets?	☐	☐
Are you happy with the way your smile looks?	☐	☐
Does food pack between your teeth or does floss shred?	☐	☐
Are you interested in tooth whitening or cosmetic dentistry?	☐	☐

HOW DID YOU HEAR ABOUT US?

(Tick one or multiple boxes, and specify where required)

	Y	N	
Google/Search Engine	☐	☐	
Facebook/Social Media	☐	☐	
HBF	☐	☐	
Community Newspaper - (E.g. Mandurah Mail, Bunbury Mail)	☐	☐	Please specify:
Major Newspaper - (E.g, Sunday Times, The Western Australian)	☐	☐	Please specify:
Radio - (E.g. 6IX, 6PR, 94.5, 96FM, Capital Radio, Curtin Radio)	☐	☐	Please specify:
Corporate Packages - (E.g. Rio Tinto, Bankwest)	☐	☐	Please specify:
Word of mouth - (E.g. friend, family, patient)	☐	☐	Name:
Prosthetist - Inno Tizzano, David Walters	☐	☐	Name:
Referring Dentist	☐	☐	Name:
Practice Staff	☐	☐	Name:
Other	☐	☐	Please specify:

WHAT IS THE PURPOSE OF TODAY'S VISIT?

I understand that by signing this form I acknowledge it is my responsibility to inform Aria Dental of any changes to my medical or personal details. ☐

NAME	SIGNATURE	DD/MM/YY

Aria DENTAL
ZANINOVICH & ASSOCIATES

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