Dr Angela Kemm, B.D.S
Dental Surgeon

Mr, Mrs, Miss, Ms, Dr...

Home Address .... Post Code......................

Work .... Home .... Mobile ....
.
D.O.B. .... Occupation: ....

E-MAIL: ....

Health fund provider: .... Patient ID: ....

Is another member of your family a patient at our office? YES / NO If No, how did you find us? ....

If Yes, Name: .... Relationship: ....

Who referred you to our office? (so we can thank them) ....

When did you last have dental treatment? ....

Previous dental x-rays were taken: ☐ Less than a year ago ☐ Longer than a year

Name of your family Doctor.. Phone: ....

What is your chief dental complaint? ....

Health History, Have you in the past or presently..........Please tick as appropriate

- Heart problems
- Blood pressure
- Artificial joints
- Rheumatic fever
- Circulatory problems
- Radiation treatment
- Excessive bleeding
- Excessive bruising
- Ulcers (stomach)
- Sinus trouble
- Tumor history
- Glaucoma
- Click or pop jaw joints

- Allergies to anaesthetics
- Allergies to penicillin
- Allergies to medications
- Allergies to latex
- Anemia or other blood disorders
- Diabetes
- Asthma
- Hepatitis A B C D E
- Epilepsy
- Liver or kidney problems
- Blood Transfusion
- HIV
- Ear aches

- Clench or grind your teeth?
- Fitted with a pacemaker or heart valve prosthesis?
- Under current medical treatment?
- Seen a doctor in the last 12 months
- Suffer from ongoing head aches

Are you taking any medication, Prescribed and or over the counter? E.g. Aspirin ....

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Women – if pregnant, how many months? ....

CONSENT FOR TREATMENT

- ☐ I hereby authorise doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
- ☐ Upon such diagnosis, I authorise doctor to perform recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- ☐ I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- ☐ I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made.

Our goal is to provide quality dental care in a timely manner. Please advise our office at least 48hrs if you are unable to attend your schedule appointment as this will enables us to better utilize available appointments for patients in need of dental care. Cancellation or rescheduling with less than 48 hours notice may attract a fee. Please discuss with our friendly staff if you need more information.

Patient signature ……………………………………………………………………………………… Date…………………………………..

Parent/ guardian signature ……………………………………………………………………… Date…………………………………..