Welcome to the Melton Dental Group

At Melton Dental Group we aim to provide you with quality dental care. Personal information including your past and present medical health is required for your dentist to provide you with safe and appropriate dental treatment.

Any information on your dental file, including information on this form, will not be disclosed to any person not involved in your dental treatment without your prior written consent. Records are strictly confidential under the Privacy Act 1988. If you would like more information about our privacy policy, a brochure is available upon request.

Melton Dental Group

First Name:	**Surname:**
Preferred Name:	**Date of Birth:**
Address:	
Suburb/Town:	**Post code:**
Mobile:	**Home:**
Work:	**Email:**
Preferred method of Maintenance reminder: ☐ SMS ☐ Letter ☐ Email	

How did you find out about us?

☐ Google ☐ Local Community ☐ Clinic Website ☐ Passing by

☐ Advertisement ☐ Referred by specialist ☐ Yellow pages ☐ Facebook

☐ Referred by a family/friend Full name of referrer (If applicable):

Emergency Contact:	**Ph:**
Private health Insurance Fund:	Membership number: Reference Number:
Medicare Number:	Reference (number next to patient's name):

Person Responsible for fees:

Please Note: Please be aware all accounts are to be paid on the day of treatment. Any unpaid accounts will incur collection costs.

Appointment cancellations require 48 hours notice. If insufficient time is given you may be required to pay a $75 deposit to rebook appointment. This deposit will come off your total account only on the agreed rescheduled date.

Signature:

PTO for medical history information

Medical History ***to the best of your knowledge do you have or have you suffered from the following?***

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ High cholesterol
- ☐ Arthritis
- ☐ Anxiety
- ☐ Autism
- ☐ Hepatitis _____
- ☐ Infectious disease (e.g HIV/STD/MRSA)
- ☐ Diabetes
- ☐ Other_____

Do you smoke? ☐ Yes ☐ No **How many per day?**

Do you drink Alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Do you have any allergies or Reactions? ☐ Yes ☐ No

If yes, please list:

Are you pregnant? ☐ Yes ☐ No **Due Date:**

Are you currently taking any of the following medications- PLEASE LIST?

- ☐ Anti-inflammatory _____
- ☐ Pain Killers _____
- ☐ Antibiotics _____
- ☐ Bisphosphonates or any medication that effects bone growth or metabolism) _____
- ☐ Heart or Blood pressure medication _____
- ☐ Cancer Medication _____
- ☐ Cancer Therapy _____
- ☐ Contraceptive Pill_____
- ☐ Asthma Inhaler/Medication_____
- ☐ Blood thinners_____
- ☐ Other_____

How long has it been since your last dental examination?

Do you have any of the following Dental Concerns?

- ☐ Toothache
- ☐ Bad Breath
- ☐ Discoloured Teeth
- ☐ Sensitive Teeth
- ☐ Dry Mouth
- ☐ Grinding/Clenching
- ☐ Bleeding gums
- ☐ Broken Teeth
- ☐ Loose/Missing Teeth

By signing this form, I am stating that the information provided is accurate to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by my dentist and their staff. I have acknowledged both payment and cancellation policies listed on the first page and understand the consequences of these.

Patient Signature: **Date: / /**

(Parent/Guardian must sign for persons under 18)