Suite 6, 16-18 Malvern Ave
CHATSWOOD NSW
Web: www.chatsdental.com.au

CHATS DENTAL

Tel: (02) 8065 1080
Mobile: 0401 SMILE7 (0401 764 537)
Email: info@chatsdental.com.au

HOW DID YOU FIND US? **GOOGLE/FORUM/ SOCIAL MEDIA/ BY REFERRAL: (Name, Relationship): _____**

**** We are a primarily referral-based dental practice and we truly appreciate all referrals ****

PATIENT DETAILS

SURNAME:	**FIRST NAME:**	**PREFERED NAME:**		**TITLE: MR/MRS/MS/MISS**
MIDDLE NAME:	**DATE OF BIRTH (DD/MM/YYYY):**	**OCCUPATION:**		**GENDER: M / F**
ADDRESS:		**SUBURB:**	**STATE:**	**POSTCODE:**
MOBILE PHONE:	**WORK PHONE:**	**HOME PHONE:**		**PREFERED CONTACT: SMS/PHONE/EMAIL**
EMAIL:		**PREFERED LANGUAGE:**		

Are you fully vaccinated against Covid-19? Yes / No

EMERGENCY CONTACT:

RELATIONSHIP(Please Circle): HUSBAND/ WIFE/PARENT/SON/DAUGHTER/GUARDIAN OR OTHER: _____		
SURNAME:	**FIRST NAME:**	**PHONE NUMBER**

PRIVATE HEALTH FUND DETAILS (Please Circle):

GU Health, nib, cua, CBHS, Bupa, HCF, medibank	**OTHER:**	**REFERENCE: (00, 01, ETC.)**

CHILD DENTAL BENEFIT SCHEDULE (ONLY IF YOU ARE UNDER 17 YEARS OF AGE):

MEDICARE CARD NUMBER:	**REFERENCE ID:**	**EXPIRY:**

MEDICAL HISTORY AND CURRENT CONDITIONS:

Your accurate and up-to-date health information is essential to be gathered by law and regulations in order to facilitate us to provide you quality management, comprehensive clinical care and for the safety of you and all health care workers. All information is kept **strictly CONFIDENTIAL** and complies with *Health Records and Information Privacy Act 2002*.

Do you need any antibiotics as a prophylactic cover for dental treatment? (name/details)	YES	NO
Are you currently taking any medications/ vitamins/ supplements? (name/dose)	YES	NO
Have you had any surgical operations (e.g. knee replacement)? (details/date)	YES	NO
Have you had/ are going to have chemotherapy/ radiotherapy? (details/date)	YES	NO
Do you have, or have had any of the following? (circle/provide further details) • **High / Low Blood Pressure, Heart concerns** (palpitations, arrhythmia, bypass, balloon pump, valve etc.) • **Asthma, Respiratory concerns** (Chronic Obstructive Pulmonary Diseases, Emphysema, Pneumonia, TB etc.) • **Diabetes** (Type I, Type II), **Kidneys concerns** (Dialysis, Urinary Tract Infection, Polycystic, Inflammatory etc.) • **Liver concerns** (Hepatitis A, B, C etc.), **Immunity concerns** (Lupus, Bone Marrow, Lymph nodes, HIV etc.) • **Bleeding concerns** (Anemia, hemoglobin, platelet, anti-coagulant) • **Allergies** (Local Anesthetics e.g. Novocain, Barbiturates, Sedatives, Aspirin, Latex, Penicillin, Sulfa etc.)	YES	NO
Do you smoke and/ or drink alcohol regularly? (___ cigarettes per day) (____ glasses per day)	YES	NO

Are you happy with your smile? Yes / No

Chats Dental takes pride in our quality dental service in all areas from general care to your specific needs

Which additional area(s) of dental services can we help you with?: whitening, implant, InvisalignGO, cosmetics, _____

TERMS AND CONDITIONS:

I understand I MUST settle my account at the end of every visit. I have to pay the FULL amount if my health fund does NOT cover my fees for any reason. All records taken (verbal, written, texts, photos, x-rays, videos, media etc.) are CONFIDENTIAL and can be used by Chats Dental Group for clinical, legal, promotional and educational purposes with my full consent.

PATIENT'S SIGNATURE: _____ **Date: _____**