griffith dental lounge

WELCOME

ABOUT YOU

Patient Name: _____

What you prefer to be called: _____ Sex: M F

Birthdate: __/__/_____ Age: ___

Mailing Address:_____

City:_____ State: _____ p/code: _____

Home Phone: _____ Work: _____

Mobile: _____

Email: _____

Referred by: _____

Employer: _____ How long? _____

Occupation: _____

DENTAL INFO

Main reason for visit: _____

Are you in any pain? _____ For how long? _____

Are you experiencing any dental problems? (circle)

Discomfort	Clicking jaw	Lost/broken filling
Blisters	Grinding	Snoring
Chipped tooth	bad breath	bleeding gums
sensitivity	locking jaw	ringing in ears

other: _____

Last exam: _____ Last clean: _____

Times a day you Brush: _____ floss: _____

Are you a smoker? Y N How many p/day: _____

Have you had orthodontic treatment? Y N

EMERGENCY

Whom should we contact? _____

Relation: _____

Home #: _____ Work #: _____

Mobile #: _____

Who is your medical doctor? _____

Doctors phone #: _____

MEDICAL INFO

What medications are you taking?: (including vitamins)

_____

Please list any surgeries or medical conditions you have or have had: _____

_____

Are you allergic to any medication?: Y N

_____

Are you allergic to latex or metals? _____

Have you ever had any of the following?: (circle)

Heart problems	Diabetes	Epilepsy
High blood pressure	Cancer	Tonsil removal
Low blood pressure	Migraines	Eye Disease
Stroke	Birth Defect	HIV/AIDS
Arthritis		

WOMEN ONLY

Are you pregnant? Y N

Are you taking oral contraceptive? Y N

INSURANCE

Are you in a private Health Fund? Y N

Are you covered for dental? Y N (skip this section if not)

Fund name: (eg, HCF, BUPA) _____

Membership #: _____ Ref #: _____

For records only - we do not bulk bill

Medicare #: _____

Ref #: _____ Exp Date: _____

CONSENT FOR TREATMENT - I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all 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 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 and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made prior to my appointment. I authorise that this data may be reviewed by team members of the dental practice. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled.

THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

Signed: _____ Date: _____/_____/_____

How did you hear about us?

☐ TV ☐ Newspaper ☐ Social Media ☐ Website ☐ Friend ☐ Other _____