Shops 4-6, Gisborne Central
10-20 Aitken St, Gisborne, VIC, 3437
T: (03) 8595 1888
www.gisbornefamilydental.com.au
hello@gisbornefamilydental.com.au
ABN: 58 968 411 883

Title: Mr/Mrs/Ms/Miss/Dr	Surname	
Given Names	Preferred Name.	DOB
Home Address	Suburb	P/Code
Ph	Mobile	
Email	Occupation	
Postal Address (if different)		
Emergency Contact	Ph	
Medical Doctor (GP)		
How did you hear about us? Google/ walked past/social media/ referred/other (please specify) If referred, referred by who:		
Do you have dental insurance? Yes / No	Name of fund?	
Medicare No		

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Heart disease	☐	☐
Cardiac Pacemaker	☐	☐	Heart surgery	☐	☐
High/low blood pressure	☐	☐	Join replacement surgery	☐	☐
Diabetes	☐	☐	Stroke/fits/epilepsy	☐	☐
Arthritis	☐	☐	Fainting	☐	☐
Asthma/Lung conditions	☐	☐	Thyroid disease	☐	☐
Tuberculosis	☐	☐	HIV/AIDS	☐	☐
Sleep Apnoea	☐	☐	Osteoporosis/bone disease	☐	☐
Hepatitis A,B,C/liver disease	☐	☐	Steroid Therapy	☐	☐
Cancer	☐	☐	Psychological condition	☐	☐
Radiation Therapy	☐	☐	Excessive Bleeding/blood disorder	☐	☐
Stomach/digestive condition	☐	☐	Pregnant	☐	☐

Do you smoke (if so how many per day?) Yes / No
Do you have any allergies (eg: penicillin, latex) Yes / No Please list:
Any other medical conditions not listed? Yes / No Please list:
Please list all medication you are taking

Declaration & Consent

I agree to the following terms:

-I acknowledge that I have filled out this form to the best of my knowledge and ability, as honestly and accurately as possible.

-I understand the need to advise my dentist of any changes to my medical history in future

-I have read and understood Gisborne Family Dental's *Privacy Policy*

-I acknowledge that the practice requires at least 24 hours notice if I need to cancel an appointment

-I am aware that full payment is required on the day of treatment. Gisborne Family Dental accepts cash, Eftpos, Mastercard, Visa & Amex.

I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated. I will assume full responsibility for the fees associated with those procedures. I understand diagnostic tools such as radiographs, photographs and study models may be required prior to the commencement of certain dental procedures.

Patient/guardian (if patient is under 18 years old): ……………………………………………………………………Date: …………………