MISSION BAY
DENTAL

COSMETIC, IMPLANTS, & GENERAL DENTAL CARE

Geoff Williamson & Associates

Welcome to our Practice

CONFIDENTIAL

Registration

Patient's FirstNames:____

Last Name: ______________________Mr, Mrs, Ms, Miss Date of Birth: __________

Physical Address: _________________________________Post Code: ______________

Postal Address: ___________________________________Post Code: ______________

Phone: Hm______________ Mobile:______________________Bus:________________

Email:______________________________ Occupation:__________________________

Are you a member of Facebook:____

Who do we thank for referring you to us:______________________________________

Name of last Dentist: ________________________ Date of last visit: _______________

Name of Doctor: ____

Medical and Dental History (Please tick)

Are you in good health?________________________________ [ ] yes [ ] no

Have you been treated in hospital during the past two years?___________ [ ] yes [ ] no

When you cut yourself do you stop bleeding normally? _____________ [ ] yes [ ] no

Do you have local anaesthetic for routine dentistry?_______________ [ ] yes [ ] no

Are you being treated by a Doctor at present? __________________ [ ] yes [ ] no

Are you a smoker? ____________________________________ [ ] yes [ ] no

Have you any allergies? _________________________________ [ ] yes [ ] no

Are you taking medicine, tablets or drugs?_____________________ [ ] yes [ ] no

If so, please list____

____

Have you now, or ever had any of the following? Please tick [ ] yes [ ] no

Replacement – Hip or Knee	High Blood Pressure	Heart Trouble
Rheumatic Fever	Diabetes	Epilepsy
Hepatitis	HIV Positive	Severe Headaches
Asthma	Kidney Disease	

Women – are you pregnant? [ ] yes [ ] months or [ ] no

Are there any other aspects concerning your health you think your Dentist should know about? [ ] yes [ ] no

If so, please note____

FINANCIAL

Payment in full on the day of treatment is required unless a prior arrangement has been made. In complicated cases with multiple appointments, part payment is required as the treatment progresses. UNPAID OR OVERDUE ACCOUNTS will incur a 9.850% interest penalty and collection costs will be the patient's responsibility. We accept Eftpos, Visa, Mastercard, American Express, Activa, Cash and Cheque methods of payment. PLEASE NOTE – All estimates of fees are based upon conditions viewed at the time of diagnosis, unforeseen circumstances can alter an estimated fee.

CANCELLATIONS

We understand that sometimes it is necessary to change your schedule. Out of consideration for others we kindly ask you to provide a minimum of 24 hours notice if you wish to change or cancel an appointment. A non-attendance fee will be charged.

I have a Dental Insurance Plan [ ] yes [ ] no Type ______________________________

Signed______________________________Date _____________________________________

If under 18 years parent/guardian _________________________Date__________________________

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