## TONGARRA ROAD FAMILY DENTAL

PLEASE FEEL FREE TO ATTACH YOUR MEDICATION LIST

## **WELCOME**

MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.         JOINT REPLACEMENT:       YES         ARTIFICIAL HEART VALVES/ VALVE DEFECT       YES         CARDIAC SURGERY       YES         PACEMAKER       YES         CONGENITAL HEART DEFECT       YES         HEART ATTACK       YES         HEART MURMUR       YES         STROKE       YES         RHEUMATIC HEART DISEASE       YES         WARFARIN / BLOOD THINNING MEDICATION       YES         DIABETES: TYPE 1 / TYPE 2       YES         DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       YES         PENICILLIN       YES       NO	ATE WH CC)? (I CC)? (I	IICH CARD: C PLEASE CIRCLE STREATMENT R SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO	GOLD / Issu Issu ES / N SPHONA US DISE S: A / B	O           N:           YES           YES           SLABORA           O           ITES:           ASES:	/ORK: CCUPATION: CCUPATION: TE DVA N NO T DATE: TOATE: TOATE: TOATE: DVA N NO T DATE: TOAT	IRN:	J SMOKE PER DAY	IECK OUT	
MOBILE:       HOME:         EMAIL:       EMERGENCY CONTACT PERSON: (NAME, RELATIONSHIP & CONTACT)         MEDICARE NUMBER:	ATE WH CC)? (1 	IICH CARD: C PLEASE CIRCLE STREATMENT R SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	GOLD / Issu Issu ES / N SPHONA US DISE S: A / B	O           N:           YES           YES           SLABORA           O           ITES:           ASES:	CCUPATION:	IRN:	Expiry: <i>Tour card upon ch</i>	YES YES	NO NO NO
EMAIL:         EMERGENCY CONTACT PERSON: (NAME, RELATIONSHIP & CONTACT)         MEDICARE NUMBER:         PRIVATE HEALTH FUND NAME:         DO YOU HAVE A DVA CARD? (PLEASE CIRCLE) YES / NO       IF YES, PLEASE INDICATE         DO YOU HAVE A HEALTH CARE CARD (HCC) OR PENSIONER CONCESSION CARD (PCC)       IF YES, PLEASE INDICATE WHICH CARD: HCC / PCC         CRN:	ATE WH CC)? (1 	IICH CARD: C PLEASE CIRCLE STREATMENT R SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	GOLD / Issu Issu ES / N SPHONA US DISE S: A / B	O           N:           YES           YES           SLABORA           O           ITES:           ASES:	CCUPATION:	IRN:	Expiry: <i>Tour card upon ch</i>	YES YES	NO NO NO
EMERGENCY CONTACT PERSON: ( <i>NAME, RELATIONSHIP &amp; CONTACT</i> )         MEDICARE NUMBER:         PRIVATE HEALTH FUND NAME:         DO YOU HAVE A DVA CARD? (PLEASE CIRCLE) YES / NO       IF YES, PLEASE INDICA         DO YOU HAVE A HEALTH CARE CARD ( <i>HCC</i> ) OR PENSIONER CONCESSION CARD ( <i>PCC</i> )       IF YES, PLEASE INDICATE WHICH CARD: HCC / PCC       CRN:         PLEASE NOTE, PENSIONER CONCESSION CARD HOLDERS ARE ENTITLED TO A 10% DISCOUNT (ENTREPLACEMENT:       ARE         MEDICAL PRACTITIONER:       ARE         MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       YES         JOINT REPLACEMENT:       YES         ARTIFICIAL HEART VALVES/ VALVE DEFECT       YES         CARDIAC SURGERY       YES         PACEMAKER       YES         HEART ATTACK       YES         HEART MURMUR       YES         STROKE       YES         RHEUMATIC HEART DISEASE       YES         NO       DAIRY	ATE WH CC)? (1 	IICH CARD: C PLEASE CIRCLE STREATMENT R SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	GOLD / Issu Issu ES / N SPHONA US DISE S: A / B	N: YES / E/STAR O I TES: B	ГЕ DVA N NO IT DATE: <b>F YES</b> , HOW M/ ONE DISEASE	IRN:	Expiry: <i>Tour card upon ch</i>	YES YES	NO NO NO
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PRIVATE HEALTH FUND NAME:       IF YES, PLEASE INDICA         DO YOU HAVE A DVA CARD? (PLEASE CIRCLE) YES / NO       IF YES, PLEASE INDICA         DO YOU HAVE A HEALTH CARE CARD (HCC) OR PENSIONER CONCESSION CARD (PCC)       CRN:	ATE WH CC)? (1 	IICH CARD: C PLEASE CIRCLE STREATMENT R SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	GOLD / Issu Issu ES / N SPHONA US DISE S: A / B	YES / YES / E/STAR O I TES: B	TE         DVA N           NO	IRN:	Expiry: <i>Tour card upon ch</i>	YES YES	NO NO NO
Do you have a DVA card? (PLEASE CIRCLE) YES / NO       IF YES, PLEASE INDICA         Do you have a Health Care Card (HCC) OR PENSIONER CONCESSION CARD (PCC)       CRN:	CC)? (I Exclude: YOU A NO NO NO NO NO	PLEASE CIRCLE STREATMENT R SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	ES / N EEQUIRING EES / N SPHONA US DISE 5: A / B	YES / e/Star 0 I TES: B	NO T DATE: FYES, HOW M/	ANY DO YOU	Expiry: Our card upon ch	YES YES YES	NO NO NO
Do you have a Health Care Card ( <i>HCC</i> ) OR Pensioner Concession Card ( <i>PC</i> )  IF YES, PLEASE INDICATE WHICH CARD: HCC / PCC  IF YES, PLEASE INDICATE WHICH CARD: HCC / PCC  REASE NOTE, PENSIONER CONCESSION CARD HOLDERS ARE ENTITLED TO A 10% DISCOUNT (EE  MEDICAL PRACTITIONER:  MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.  JOINT REPLACEMENT:	CC)? (I Exclude: YOU A NO NO NO NO NO	PLEASE CIRCLE STREATMENT R SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	ES / N EEQUIRING EES / N SPHONA US DISE 5: A / B	YES / e/Star 0 I TES: B	NO T DATE: FYES, HOW M/	ease show y	OUR CARD UPON CH	YES YES YES	NO NO NO
IF YES, PLEASE INDICATE WHICH CARD: HCC / PCC       CRN:         PLEASE NOTE, PENSIONER CONCESSION CARD HOLDERS ARE ENTITLED TO A 10% DISCOUNT (E         MEDICAL PRACTITIONER:       ARE         MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       JOINT REPLACEMENT:	YOU A NO NO NO NO NO NO	BISPHOS EPILEPSY ASTHMA INFECTIO	ISSU REQUIRING TES / N SPHONA US DISE S: A / B	O I TES: B	T DATE: <i>ATORY WORK). PL</i> <b>F YES</b> , HOW MJ ONE DISEASE	ANY DO YOU	OUR CARD UPON CH	YES YES YES	NO NO NO
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MEDICAL PRACTITIONER:       ARE         MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       JOINT REPLACEMENT:       YES         JOINT REPLACEMENT:       YES         ARTIFICIAL HEART VALVES/ VALVE DEFECT       YES         CARDIAC SURGERY       YES         PACEMAKER       YES         CONGENITAL HEART DEFECT       YES         HEART ATTACK       YES         HEART MURMUR       YES         STROKE       YES         RHEUMATIC HEART DISEASE       YES         WARFARIN / BLOOD THINNING MEDICATION       YES         DIABETES: TYPE 1 / TYPE 2       YES         DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       YES         PENICILLIN       YES       NO	YOU A NO NO NO NO NO	SMOKER? Y BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	ES / N PHONA US DISE S: A / B	O I TES: B ASES:	F YES, HOW M	ANY DO YOU	J SMOKE PER DAY	YES YES YES	NO NO NO
MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.         JOINT REPLACEMENT:       YES         ARTIFICIAL HEART VALVES/ VALVE DEFECT       YES         CARDIAC SURGERY       YES         PACEMAKER       YES         CONGENITAL HEART DEFECT       YES         HEART ATTACK       YES         HEART MURMUR       YES         STROKE       YES         RHEUMATIC HEART DISEASE       YES         WARFARIN / BLOOD THINNING MEDICATION       YES         DIABETES: TYPE 1 / TYPE 2       YES         DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       YES         PENICILLIN       YES       NO	NO NO NO NO NO	BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	DPHONA US DISE S: A / B	TES: B	ONE DISEASE			YES YES YES	NO NO NO
MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.         JOINT REPLACEMENT:       YES         ARTIFICIAL HEART VALVES/ VALVE DEFECT       YES         CARDIAC SURGERY       YES         PACEMAKER       YES         CONGENITAL HEART DEFECT       YES         HEART ATTACK       YES         HEART MURMUR       YES         STROKE       YES         RHEUMATIC HEART DISEASE       YES         WARFARIN / BLOOD THINNING MEDICATION       YES         DIABETES: TYPE 1 / TYPE 2       YES         DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       YES         PENICILLIN       YES       NO	NO NO NO NO NO	BISPHOS EPILEPSY ASTHMA INFECTIO HEPATITIS	DPHONA US DISE S: A / B	TES: B	ONE DISEASE			YES YES YES	NO NO NO
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WARFARIN / BLOOD THINNING MEDICATION       YES         DIABETES: TYPE 1 / TYPE 2       YES         DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       PENICILLIN         YES       NO	NO	THYROID		FR				YES	NO
DIABETES: TYPE 1 / TYPE 2     YES       DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.       PENICILLIN     YES       NO     DAIRY	NO				SH/LOW			YES	NO
DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.         PENICILLIN       YES       NO       DAIRY	NO				TE:			YES	NO
PENICILLIN YES NO DAIRY									
			YES	NO	LATEX			YES	NO
CODEINE YES NO CHLORHEXIDINE			YES	NO	Metals			YES	NO
PLEASE LIST ALL OTHER ALLERGIES HERE:			ļ						<u> </u>
PLEASE LIST ALL OTHER MEDICAL CONDITIONS HERE:									
PLEASE LIST ALL MEDICATIONS HERE:									
PLEASE LIST ALL MEDICATIONS HERE:									

## TONGARRA ROAD FAMILY DENTAL

Shop 7/146 Tongarra Road, Albion Park • (02) 9146 6126 info@tongarraroadfamilydental.com.au TONGARRAROADFAMILYDENTAL .COM.AU

PRACTICE TERMS AND CONDITIONS	Please initial each box to acknowledge you have read and understood our T&C's
UNDERSTAND THAT IT IS A POLICY AT THIS PRACTICE THAT FULL PAYMENT IS REQUIRED ON THE DAY OF TREATMENT.	
UNDERSTAND THAT BY CHOOSING A PAYMENT PLAN OPTION THAT THIS WILL FORFEIT ANY FORESEEABLE DISCOUNT ON MY ACCOUNT.	
UNDERSTAND THAT BY CHOOSING A PAYMENT PLAN OPTION, THAT A SURCHARGE MAY BE INCURRED.	
Tauthorise TRFD to take photographs or videos of my face, JAW and teeth when required for record keeping purposes during treatment. I further understand that if the photographs and/or videos are used, it will be at my consent and that my name or other identifying information will be kept confidential.	
Health fund Claiming         IF YOU HAVE DENTAL COVER THROUGH YOUR HEALTH FUND, WE CAN CLAIM ELECTRONICALLY THROUGH HICAPS ON YOUR BEHALF.         HOWEVER, WE REMIND YOU THAT YOUR SPECIFIC POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR HEALTH FUND. YOU ARE         RESPONSIBLE FOR YOUR TOTAL OBLIGATION SHOULD YOUR INSURANCE BENEFITS RESULT IN LESS COVERAGE THAN ANTICIPATED.         ELECTRONIC HICAPS CLAIMING MUST BE ON THE SAME DAY THE SERVICE IS PROVIDED, SO IF YOU FORGET YOUR CARD YOU WILL NEED TO         PAY THE FULL ACCOUNT AND THEN CONTACT YOUR HEALTH FUND FOR YOUR REBATE.	
<b>I UNDERSTAND THAT APPOINTMENTS OVER 59MINUTES OF TIME REQUIRE A DEPOSIT OF \$100.</b> THIS WILL BE ATTRIBUTED TO YOUR FUTURE TRANSACTION HOWEVER, IS NON-REFUNDABLE FOR LATE CANCELLATIONS OR NO SHOWS. WE VALUE THE TIME THAT YOU SPEND WITH US AND WANT TO ENSURE THAT TIME IS SET ASIDE SPECIFICALLY FOR YOUR NEEDS. WE HAVE THE BOOKING DEPOSIT IN PLACE TO LIMIT THE LOSS OF TIME AND APPOINTMENTS FOR OTHER PATIENTS WHO MAY BE IN PAIN OR DISCOMFORT.	
CANCELLATION POLICY WE REQUIRE 24 HOURS' NOTICE SHOULD YOU NEED TO CANCEL AN APPOINTMENT, WE OFTEN HAVE PATIENTS ON STANDBY OR IN PAIN WANTING TO BE SEEN, SO WE ASK THAT YOU CONSIDER THIS WHEN YOU CALL TO CANCEL OR RE-SCHEDULE. IF YOU MAKE A TIME TO SEE US AND DO NOT TURN UP TO THE APPOINTMENT, WE WILL REQUIRE A \$55.00 BOOKING DEPOSIT TO SECURE THE NEXT APPOINTMENT YOU MAKE.	
The deposit requested is based on the time allocated for the future booking; \$55 for shorter appointments and up to \$200 for longer appointments.	
TONGARRA ROAD FAMILY DENTAL RESERVE THE RIGHT TO REQUEST PATIENTS WHO CONTINUALLY CANCEL APPOINTMENTS AT SHORT NOTICE, FAIL TO ATTEND OR ARRIVE LATE TO SOURCE ANOTHER SERVICE PROVIDER.	
I UNDERSTAND THAT CANCELLATION FEE'S WILL APPLY IF I DO NOT ALLOW 24HOURS NOTICE TO THE PRACTICE.	
I UNDERSTAND THAT NO-SHOW FEE'S WILL APPLY IF I DO NOT SHOW UP FOR MY SCHEDULED BOOKING.	

HOW DID YOU FIND OUT ABOUT US? PLEASE TICK THE CORRESPONDING BOX BELOW.						
STAFF MEMBER OF TRFD		HEALTH FUND		PATIENT REFERRAL		
GOOGLE/INTERNET/FACEBOOK		GOVERNMENT CLINIC		WALKED IN/PAST		
Word of mouth		OTHER – PLEASE SPECIFY:				

SIGNATURE:	PATIENT / PARENT / GUARDIAN	DATE:		
WE LOOK FORWARD TO BEING A VALUED PARTNER IN YOUR ORAL HEALTH JOURNEY AND CAN'T WAIT TO KEEP YOU SMILING FOR YEARS TO COME!				