TONGARRA ROAD
FAMILY DENTAL

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

WELCOME

TITLE:	GIVEN NAME:	SURNAME:	D.O.B:
ADDRESS:			
MOBILE:	HOME:	WORK:	
EMAIL:		OCCUPATION:	
EMERGENCY CONTACT PERSON: (*NAME, RELATIONSHIP & CONTACT*)			

MEDICARE NUMBER: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____	IRN: ____ ____	EXPIRY: ___ ___ / ___ ___
PRIVATE HEALTH FUND NAME:		IRN: ____ ____
DO YOU HAVE A DVA CARD? (PLEASE CIRCLE) YES / NO	**IF YES**, PLEASE INDICATE WHICH CARD: GOLD / WHITE	DVA NUMBER:
DO YOU HAVE A HEALTH CARE CARD *(HCC)* OR PENSIONER CONCESSION CARD *(PCC)*? *(PLEASE CIRCLE)* YES / NO		
IF YES, PLEASE INDICATE WHICH CARD: HCC / PCC	CRN: __ __ __ __ __ __ __ __ __	ISSUE/START DATE: / EXPIRY:
PLEASE NOTE, PENSIONER CONCESSION CARD HOLDERS ARE ENTITLED TO A 10% DISCOUNT (EXCLUDES TREATMENT REQUIRING LABORATORY WORK). PLEASE SHOW YOUR CARD UPON CHECK OUT.		

MEDICAL PRACTITIONER:	ARE YOU A SMOKER? YES / NO	**IF YES**, HOW MANY DO YOU SMOKE PER DAY? _____

MEDICAL HISTORY: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.

JOINT REPLACEMENT: _____	YES	NO	BISPHOSPHONATES: BONE DISEASE	YES	NO
ARTIFICIAL HEART VALVES/ VALVE DEFECT	YES	NO	EPILEPSY	YES	NO
CARDIAC SURGERY	YES	NO	ASTHMA	YES	NO
PACEMAKER	YES	NO	INFECTIOUS DISEASES: _____	YES	NO
CONGENITAL HEART DEFECT	YES	NO	HEPATITIS: A / B / C	YES	NO
HEART ATTACK	YES	NO	AIDS/ HIV	YES	NO
HEART MURMUR	YES	NO	ABNORMAL BLEEDING	YES	NO
STROKE	YES	NO	ORAL CANCER	YES	NO
RHEUMATIC HEART DISEASE	YES	NO	THYROID DISORDER	YES	NO
WARFARIN / BLOOD THINNING MEDICATION	YES	NO	BLOOD PRESSURE: HIGH / L O W	YES	NO
DIABETES: TYPE 1 / TYPE 2	YES	NO	PREGNANT? DUE DATE: _____	YES	NO

DENTAL ALLERGIES: PLEASE CIRCLE THE CORRESPONDING BOX BELOW.

PENICILLIN	YES	NO	DAIRY	YES	NO	LATEX	YES	NO
CODEINE	YES	NO	CHLORHEXIDINE	YES	NO	METALS	YES	NO

PLEASE LIST ALL OTHER ALLERGIES HERE:

PLEASE LIST ALL OTHER MEDICAL CONDITIONS HERE:

PLEASE LIST ALL MEDICATIONS HERE:

PLEASE FEEL FREE TO ATTACH YOUR MEDICATION LIST

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PRACTICE TERMS AND CONDITIONS	PLEASE INITIAL EACH BOX TO ACKNOWLEDGE YOU HAVE READ AND UNDERSTOOD OUR T&C'S
I UNDERSTAND THAT IT IS A POLICY AT THIS PRACTICE THAT **FULL PAYMENT IS REQUIRED ON THE DAY OF TREATMENT**.	
I UNDERSTAND THAT BY CHOOSING A **PAYMENT PLAN OPTION THAT THIS WILL FORFEIT ANY FORESEEABLE DISCOUNT** ON MY ACCOUNT.	
I UNDERSTAND THAT BY CHOOSING A **PAYMENT PLAN OPTION, THAT A SURCHARGE MAY BE INCURRED**.	
I AUTHORISE 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.	
I UNDERSTAND THAT APPOINTMENTS OVER 59MINUTES OF TIME REQUIRE A DEPOSIT OF $100. 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!	