CHILD ACQUAINTANCE FORM

All information completed on this form will remain strictly confidential.
Please complete in **CAPITAL LETTERS.**

Title (please circle): Master Miss

Patient Name (in full): _____

Home Address:_____

School: _____ D.O.B._____/_____/_____

Phone Numbers: Home: _____

Parent / Child: Mobile: _____ Email: _____

How did you hear about North Shore Dentistry?_____

Emergency Contact

Name: _____ Phone Number: _____

We remind our patients of their appointments. Please tick your preferred means of contact:

Home Phone ☐ Work Phone ☐ Mobile ☐ SMS to Mobile ☐ Email ☐

Dental History

Is he/she experiencing the following dental problems? ☐ Mouth breathing ☐ Grinding /clenching teeth

How often does he/she have dental examinations? _____

How often do they brush their teeth? _____ How often do they floss? _____

What is the main purpose for his/her visit today? _____

How long since their last dental visit? _____

Does dental treatment make him/her nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have they ever had or require the following for dental treatment?

☐ Gas (Nitrous Oxide - laughing gas) ☐ General Anaesthesia

Medical History

Name of your GP: _____ Phone: _____

Address: _____

Has he/she had any serious illness in the last 2 years? If yes, please provide more information:

_____

North Shore Dentistry
1311 Pacific Hwy, Turramurra NSW 2074
P: (02) 9449 9366
E: reception@northshoredentistry.com.au

Is he/she taking any medication regularly? If yes, please provide more information:

_____

Do they have any allergies to Penicillin or other drugs? If yes, please provide more information?

_____

Do they suffer from sleep apnoea/snoring? _____ Do you play any sport? If so, what sport?_____

Do they suffer from allergies? If so, are they being treated for it?_____

Terms of Acceptance

1/. All dental treatment is carried out using the latest techniques, equipment and materials. All equipment is either disposable or sterilised using an autoclave which is validated daily for optimal efficiency.

2/. It is the policy of this practice to take diagnostic radiographs (x-rays) at the first examination and specific radiographs (x-rays) as required before certain procedures.

3/. Any treatment required will be provided with the patient's informed consent after all risks associated with the treatment are outlined.

4/. All information on this form is considered confidential and is necessary to ensure that the best possible treatment can be provided.

5/. Each appointment made is a contract between North Shore Dentistry and the patient. All appointments cancelled with less than 24 hours notice will incur a $100 cancellation fee to help cover costs.

6/. An estimate of fees for treatment should be outlined prior to treatment being provided. If you are not sure of estimated fees, please let our Practice Manager or your Dentist know.

7/. All fees incurred per appointment must be settled at the completion of that appointment, unless a payment plan has been created with your Dentist or the Practice Manager.

8/. Dishonoured cheques will incur a $50.00 dishonour fee.

9/. Should any account for any reason become outstanding, then the patient, or person responsible for accounts, will be responsible for all debt collection charges incurred.

10/. Should any photographs be taken of you, please confirm if you are happy for these to be used for:

Research Purposes: Face ☐ Teeth Only ☐ Marketing Purposes: Face ☐ Teeth Only ☐

I _____ confirm that the medical history provided is a true indication of my health at this time, I also agree to the terms set out above.

Signed (Parent/Guardian) _____ Date_____/_____/_____

North Shore Dentistry
1311 Pacific Hwy, Turramurra NSW 2074
P: (02) 9449 9366
E: reception@northshoredentistry.com.au

North Shore™ Dentistry
HEALTHY SMILES FOR LIFE

ADA AUSTRALIAN DENTAL ASSOCIATION INC.