CHILD MEDICAL/DENTAL HISTORY

It is important to know details about your medical history as this can affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is strictly confidential.

CHILD DETAILS

Master/Miss:	Last Name:
Date of Birth: / /	First Name(s):
Home address:	

PARENT/CARER DETAILS

Name:		Relationship:
Mobile:	Home:	Work:
Home address (if different to above):		
Emergency contact: (if different from above)		
Email address:		Please tick if you wish to opt out of practice emails ☐
How did you find out about our practice?:		
Who is your medical practitioner:	Phone number:	Health fund:

I have confidential medical information that I do not wish to write down, I would prefer to speak to a dentist about this (please tick box) ☐

	YES	NO	DETAILS
Do you normally require antibiotic cover before dental treatment?			
Have you had any abnormal reactions to local or general anaesthesia?			
Are you being treated by a doctor at present?			
Are you taking any prescription (or other) medications at present?			
Have you been hospitalised in the last 12 months?			
Have you or anyone in your household returned from overseas travel in the last 10 days?			

Please list any current medications:

Please list any drugs or medicines you are allergic to:

Please list any other known allergies (including latex, food and preservatives):

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

(Please tick appropriate box)

	Yes	No		Yes	No		Yes	No
Snoring			Bed wetting			Difficulties in concentrating		
Mouth breather			Sleep walking			Poor school performance		
Tooth grinding			Night terrors			Hyperactivity		
Asthma			Difficulty swallowing			Diagnosed with ADHD		
Enlarged tonsils or adenoids			Sleep apnoea (child stops breathing)			Behavioural problems		
Middle ear infections			Daytime tiredness			Anxiety/depression		

Does your child wake up feeling tired, or do you think your child has NOT had a good night sleep? (please circle) Yes No

Please list any other conditions not mentioned:

When was your last dental examination?:

Who was your previous Dentist?:

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH

How do you wish to be contacted for confirmation/reminders and recalls?

Email ☐ **SMS** ☐ **Phone Call** ☐

Patient signature (parent/guardian if under 16):	Date:

Yandina Dental

OUR APPOINTMENT POLICY

We understand that you may need to reschedule an appointment due to an emergency or an obligation with family or work, and sometimes these situations cannot be avoided.

(Please tick the boxes below)

☐ We are the only dental practice in Yandina which means our Dentists are in high demand, so when a patient does not call to cancel an appointment, they are preventing another patient from being seen. We would like a minimum of 24hrs' notice if you need to reschedule, so we may allocate this time for a patient who is need of our services. Whereby less than 24 hours' notice has been given before cancelling or on failing to attend, we may ask you to place a non-refundable deposit of $100.00 to secure future appointments.

☐ We will confirm your appointment 1-2 days prior as a courtesy. You can confirm this by replying 'Y', otherwise we require a phone call if you need to reschedule. Replying to the text **IS NOT RECOGNISED** by our system so please ensure you have the courtesy to call.

☐ We appreciate that everyone has busy lives and we aim to run on time for all of our appointments. To help us to do this, we ask that you arrive at least 5 minutes before your scheduled time so can promptly see you.

☐ **Any abusive behaviour WILL NOT be tolerated**. We take any threat, intimidation or harassment of our staff and members very seriously. If it is deemed necessary in order to protect the safety of any member of staff, we will report any behaviour of this type to the appropriate authority (which may include the police).

☐ We require you to turn OFF your mobile phones whilst in the treatment rooms.

☐ **Payment is required on the day of treatment as we do not hold accounts.**

I confirm that I have read the above, understand the practice policy, and will provide 24 hours' notice if I am unable to attend an appointment.

Signed: _____ Date: _____