



WELCOME TO ALL CARE FAMILY DENTIST!

We are delighted that you have chosen our practice to provide your dental care. For your comfort and peace of mind, we have provided you with some information about your first visit to our practice.

Our practice is located in the Ray Rickard Medical Centre. The details are as follows:

Address: 6 Station Street, Fairfield NSW 2165 (a map is enclosed)
Phone: (02) 9723 3355
Fax: (02) 9727 0656
Web Page: www.acdental.com.au
Opening hours:
Monday to Friday: 9:00am-5pm (appointments before 9am and after 5pm by arrangement)
Saturday: 9:00am-4.30pm

- We schedule our appointments carefully to avoid you having to wait. Your time is valuable and we will always treat it with respect. We do cater for emergencies throughout the day, so if for some reason your appointment is delayed we will apologise in advance.
- Your dentist will meet with you one on one to discuss your dental needs and expectations.
- A complete comprehensive oral examination will be given to determine the type of dental care appropriate for you. We have found that prevention is the key to healthy teeth and gums.
- Diagnostic radiographs (x-ray) may be taken at your first and subsequent consultations to assist us in evaluating any decay, infection, bone loss, soft and hard tissue abscess.
- If you could fill in the enclosed paperwork before you arrive in the office. This will assist in making your visit run as smoothly and quickly as possible.
- If for some reason you cannot keep your reserved time, please give us 24 hours' notice so that we can offer the time to another patient. A cancellation charge of \$50 will be applied to any appointment that is cancelled within a 24 hour period of your appointment time.

Our entire team is dedicated to your wellbeing. We are enthusiastic about what dentistry can offer everyone. We are committed to bringing the highest level of care and professionalism possible.

If there are any questions you may have about your appointment with us, please don't hesitate to call us on 9723 3355.

We look forward to seeing you.

Kind regards,

Team at All Care Family Dentist.



CONFIDENTIAL PATIENT QUESTIONNAIRE

Please answer these questions as completely as possible to enable us to provide the highest standard of care. All information will be treated with complete professional confidentiality

First Name: Title:
Surname: Date of Birth:
Address:
Postcode: Telephone (H) (M) (W)
Occupation: Email:
Have you any Dental Health Cover? Which Fund?
Who recommended you to our Dental Practice?
Medicare Card No: Person: 1 /2 /3 /4 / Expire:

Details of person to contact in an emergency:

Name: Phone Number:
Medical Doctors Name: Phone (If known):

Do you have or have you ever had any of the following? (If YES please mark the box)

- Rheumatic Fever/ Heart Murmur
Heart Trouble/ Heart Surgery
High Blood Pressure
Kidney or Liver Disease
Arthritis
High Cholesterol
Hepatitis
Radiation Treatment
Diabetes
Gastric Problems
Asthma
Sinus or Respiratory Problems
Epilepsy or Nervous Disorder
Bleeding Disorder
Smoke.....How Much?
Allergies

- 1. Do you take any medications? YES/ No If "Yes" please fill back page
2. Do you consider that you may be in a high risk group for HIV or Hepatitis B?
3. Have you been a patient in hospital in the past? Yes / No
Reason: Date:
4. Woman, if pregnant please state number of weeks and due date?

DENTAL HISTORY

- 1. Approximate date of last dental visit:
2. Have you had any problems with past dental treatment? Yes / No
3. Main concern today?

Are you concerned about the appearance of your teeth/colour/smile?

Signed: Patient/Parent/Guardian Date:



Ray Rickard Medical Centre
6 Station Street,
Fairfield NSW 2165
Provider No. 955552Y
Phone: 9723 3355
Fax: 9727 06 56

PLEASE LIST ANY MEDICATIONS YOU MAY BE TAKING (INCLUDING herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants) so we can take appropriate cautions and avoid drug interactions.

| Drug name | Dose | Duration of treatment | Purpose |
|-----------|------|-----------------------|---------|
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Please list any known **ALLERGIES** or **ADVERSE REACTIONS** to drugs (especially antibiotics eg. penicillin), medicines, antiseptics, local anaesthetics, preservatives that we should know about.

| Drug name | Nature of reaction | How long ago |
|-----------|--------------------|--------------|
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Date:

Signature: