TLC Dental

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Dr Leonard Hoffenberg
BSc. BDS

Patient Details

Title: Dr/Mr/Mrs/Ms/Miss Surname: _____

First Name: _____

Who should we thank for referring you to us? _____

Address: _____

Suburb: _____ Post Code: _____

Date of Birth: _____

Phone No. Work: _____ Home: _____

Mobile: _____ Email: _____

Patient's Occupation: _____

Private Health Fund Cover: ☐ Yes ☐ No If Yes, What Fund? _____

General Medical Practitioner: _____

Emergency Contact: _____ Phone No. _____

Name of Person Responsible for Payment

Full Name: _____

Name of Organisation: _____

Address of Organisation: _____

_____

Phone No. _____

Medical History

Have you ever had:

Heart Disease:	☐ Yes	☐ No	High Blood Pressure:	☐ Yes	☐ No
Rheumatic Fever:	☐ Yes	☐ No	Diabetes/inherited Disease:	☐ Yes	☐ No
Allergies:	☐ Yes	☐ No	Asthma, Chest Disease:	☐ Yes	☐ No
Joint replacement:	☐ Yes	☐ No	Blood Disease/Bleeder etc.:	☐ Yes	☐ No
Stomach Ulcers:	☐ Yes	☐ No	Snoring problems:	☐ Yes	☐ No

Infectious Diseases e.g. HIV, AIDS, Hepatitis A, B or C or any other illnesses of significance we should know of? _____

Are You on Any Medications e.g. Cortisone, Warfarin? _____

_____

Females: Are you pregnant? _____

Signed: _____ Date: _____

Consent for Treatment

1. I hereby authorise doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by a doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorise doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to use the anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made.

Patient's Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Relationship:** _____

'Exceptional dental care is your right and our responsibility'