SEMAPHORE DENTAL
caring for your smile

It is important to know about your medical history as it could affect your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy.

Medical History Form – Children (0 – 17years)

TITLE: (PLEASE CIRCLE) MISS MASTER ☐ MALE ☐ FEMALE

SURNAME: _____ GIVEN NAMES: _____

PREFERRED NAME: _____ DATE OF BIRTH: _ _ / _ _ / _ _ _ _

ADDRESS: _____

PHONE (H) _ _ _ _ _ _ _ _ (M) _ _ _ _ _ _ _ _ _ _

EMAIL: _____

EMERGENCY CONTACT DETAILS

SURNAME: _____ GIVEN NAMES: _____

RELATIONSHIP TO CLIENT: _____

PHONE (H) _ _ _ _ _ _ _ _ (M) _ _ _ _ _ _ _ _ _ _

How would you like to be contacted for appointment reminders? ☐ SMS ☐ Email ☐ Phone call

WHAT MADE YOU CHOOSE US?

☐ Our Website ☐ Signs ☐ Family Doctor ☐ BUPA ☐ Yellow Pages (please circle: Book/Online) ☐ Radio
☐ White Pages (please circle: Book/Online) ☐ Friend Referral (please specify who) _____

PAYMENT

Are you in a Private Health Fund? ☐ Yes ☐ No If so, specify which one: _____

Medicare Card Number: _____ Childs Line Number: _____

Do you know if your child is eligible for the Child Dental benefit Scheme? _____

MEDICAL HISTORY - Does your child have or has had any of the following medical conditions? (Please tick)

☐ Heart Disease	☐ HIV/AIDS	☐ Liver Disease
☐ Heart Murmur	☐ Epilepsy	☐ Kidney Disease
☐ Artificial Heart Valve	☐ Diabetes 1 or 2 (circle)	☐ Asthma
☐ High Blood Pressure	☐ Radiation or Chemotherapy	☐ Low Blood Pressure
☐ Pacemaker	☐ Hepatitis A/B/C (circle)	☐ Bleeding Problems
☐ Thyroid Disease	☐ Cancer	☐ Depression/Anxiety (circle)

Please specify any other medical conditions not listed: _____

Does your child take any medication? (including supplements or injections)_____

Does your child have any allergies? _____

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DENTAL HISTORY

How often does your child visit the dentist? _____

Does your child experience anxiety visiting the dentist? _____

Are you concerned about any crowding issues your child may have? _____

Does your child snore or breathe loudly during sleep? _____

Does your child sleep with their mouth open? _____

Does your child wet the bed? (this could be an airway issue) _____

Does your child still use a pacifier or suck their thumb? _____

Payment of Account: Full payment of the account is due at your appointment. If you are unable to pay your account in full, please speak to our front desk staff prior to your appointment. Should the health fund claim be rejected for any reason, the patient will be responsible for payment of the full account on the day of treatment.

Please ensure that you bring your health fund card to every appointment to claim using our HICAPS machine. If you do not have your card you will need to pay in full and claim your benefit back from your health fund directly.

Please note, the responsible party will be liable for any debt collection fees incurred if payment is not received within our settlement terms.

Appointment Cancellation and Failing to Attend Policy: We reserve your appointment at the time of booking. We provide a courtesy confirmation reminder service via SMS, telephone or email prior to all appointments. If you need to reschedule your appointment please call our clinic to arrange a suitable time.

Patients that cancel appointments less than 48 hours' notice, or fail to attend an appointment, greatly impact our ability to provide quality dental care and offer appointments to other patients in need. We understand that 48 hours' notice isn't always possible and we will take each circumstance into consideration. We reserve the right to charge a $100 cancellation fee for late notice cancellations or for missed appointments. By signing this form you have read and accept the policies listed above.

Parent/Responsible Party's Signature: _____ Relationship to Patient: _____

Date: _____