Welcome to Quality Dental Care

Please be aware that we require payment on the day of treatment

QDC
QUALITY **DENTAL** CARE

Personal Details

Full name: Mr. Mrs. Ms. | First name | Surname | Date of birth / /

Preferred name | Email

Address | City/Suburb | Post code

Telephone | Home | Work | Mobile

Occupation | Employer

Business Address

How did you hear about us? Local newspaper ☐ Yellow Pages ☐ Walking past ☐ Referral ☐ Brochure ☐

If referred, please state who referred you

Are you interested in Tooth Whitening ☐ Cosmetic Dentistry ☐ Implants ☐

Are you happy with the appearance of your teeth/smile? Yes ☐ No ☐

Medical Details

What dental benefits/insurance do you have?

Have you had (tick if applicable) Any serious health problems during the past? ☐ Any adverse reaction to any treatment or medication? ☐

Do you take drugs/medicine regularly? Yes ☐ No ☐

If yes to any of the above please give details

Do you have, or have you ever suffered from any of the following? (tick if applicable and please give details)

☐ Hepatitis, HIV
☐ Rheumatic Fever
☐ **Penicillin Allergy**
☐ Allergies or Hypersensitivity e.g. latex, etc
☐ Heart or Vascular Disorder
☐ Blood Disease (Bleeder)
☐ Blood Pressure Problems
☐ Epilepsy
☐ Diabetes
☐ Liver or Kidney Disease
☐ Asthma
☐ Other Problems

Are you pregnant? Yes ☐ No ☐ Are you breast feeding? Yes ☐ No ☐

Who is your doctor? Do you usually have antibiotic cover for your dental treatment? Yes ☐ No ☐

Do you have any problems with dental injections? Yes ☐ No ☐ If yes, please give details

I agree to pay all costs associated with the recovery of any debts that may be incurred by me. | Signature | Date / /