

We're changing lives.....One smile at a time!

Dr Bob Gibbins  
Provider No 537122K

Dr Mimi Tam  
Provider No 2469375A

Dr Lissome Leung  
Provider No 2753824T

## Welcome to Future Dental

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Postal address: \_\_\_\_\_

\_\_\_\_\_ Post code \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Recommended to us by: \_\_\_\_\_

Purpose of visit: \_\_\_\_\_

The name of your Private Health Fund: \_\_\_\_\_

Is another member of your family a patient at our office:  Yes  No

Have you had any of the following?

- |                           |                              |                                  |                              |
|---------------------------|------------------------------|----------------------------------|------------------------------|
| Heart Problems            | <input type="checkbox"/> Yes | Allergies to penicillin          | <input type="checkbox"/> Yes |
| Blood Pressure            | <input type="checkbox"/> Yes | Allergies to medications         | <input type="checkbox"/> Yes |
| Artificial joints         | <input type="checkbox"/> Yes | Allergies to latex               | <input type="checkbox"/> Yes |
| Rheumatic Fever           | <input type="checkbox"/> Yes | Anaemia or other blood disorders | <input type="checkbox"/> Yes |
| Circulatory problems      | <input type="checkbox"/> Yes | Diabetes                         | <input type="checkbox"/> Yes |
| Radiation treatment       | <input type="checkbox"/> Yes | Asthma                           | <input type="checkbox"/> Yes |
| Excessive bleeding        | <input type="checkbox"/> Yes | Osteoporosis                     | <input type="checkbox"/> Yes |
| Excessive bruising        | <input type="checkbox"/> Yes | Epilepsy                         | <input type="checkbox"/> Yes |
| Stomach Ulcers            | <input type="checkbox"/> Yes | Liver or Kidney Problems         | <input type="checkbox"/> Yes |
| Sinus trouble             | <input type="checkbox"/> Yes | Blood borne viruses including:   |                              |
| Tumour history            | <input type="checkbox"/> Yes | HIV, Hepatitis B or C            | <input type="checkbox"/> Yes |
| Allergies to anaesthetics | <input type="checkbox"/> Yes |                                  |                              |

Are you currently taking any medications:  Yes  No

If YES, please list: \_\_\_\_\_

Have you had any of the following?

- Does your jaw click or hurt?  Yes
- Do you feel you grind your teeth?  Yes
- Have you ever had orthodontic treatment?  Yes
- Do you wear a night guard?  Yes
- Have you ever had gum disease?  Yes
- Have you ever had your bite adjusted?  Yes
- Do you bite your lips or cheeks often?  Yes
- Do you smoke?  Yes
- Do you think you have occasional bad breath?  Yes

- Do your gums ever bleed when you brush your teeth?  Yes
- Do you experience sensitivity with hot/cold?  Yes
- Does floss ever catch between your teeth?  Yes
- Does food get jammed between your teeth?  Yes
- Do your teeth ever hurt when you bite hard?  Yes
- Do you snore?  Yes

Other notes:

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Name of your physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you pregnant?  Yes. If yes, what is the due date? \_\_\_\_\_

How long since your last dental appointment? \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

Previous dental xrays were taken:  Less than a year ago  Longer than a year

We accept cash, cheques, visa, mastercard. We also accept American Express and Diners with a surcharge of 3%. We also offer interest free payment plans through GE Finance to approved applicants. We respectfully ask that all treatment is paid for at the time of your treatment. Accounts are not given and any balance outstanding may incur interest at 1.5% per month compounding, plus account maintenance fees of \$15.00 per month. Any dishonored bank cheques that incur a fee are passed onto the client. We ask that should you need to re-schedule or shorten your dental appointment, at least 48 hours notice is given. Your appointment time has been reserved exclusively for you. Any change to this appointment may affect many others.

***Financial Consent***

I agree to be responsible for payment of all services rendered on behalf of myself and on behalf on my dependents. I understand that payment is due at the time of service.

Signature: \_\_\_\_\_ Date \_\_\_\_ - \_\_\_\_ - 20\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_ - \_\_\_\_ - 20\_\_\_\_