Nita Pai
BDS (Adel) MDS (Adel)
PAEDIATRIC DENTIST

Suite 503/35
35 Spring Street
Bondi Junction NSW 2022

WELCOME TO OUR DENTAL PRACTICE
Specialist dental care for infants, children and adolescents.

PLEASE COMPLETE ALL QUESTIONS ON BOTH SIDES. The information requested will assist us to treat your child and will remain strictly confidential.

Please complete in BLOCK LETTERS

Patient Information

Surname: _____ Given names: _____

Date of birth: _____ Sex: ____ School:_____

Patient's address (No P.O. Box): _____

Suburb: _____ Postal Code: _____

Mother's Surname: _____ First Name: _____

Mobile Phone: _____ Work Phone: _____

Father's Surname: _____ First Name: _____

Mobile Phone: _____ Work Phone: _____

Main mobile phone: _____ **Main E-mail:** _____

****Main Mobile number and email address will be used for appointment reminders.**

Who may we thank for this referral?

Dr. _____ Practice: _____

Have any of your other children seen Dr Pai previously? Yes☐ No☐

Name and Address of family doctor? _____

Health Insurance Details

Yes☐ No☐ Do you have private health insurance? If yes,

Fund Name: _____ Membership No. _____

Yes☐ No☐ Hospital Cover?

Yes☐ No☐ Dental Cover?

Dental History

Yes☐ No☐ Is it your child's first dental check up?
Yes☐ No☐ Has your child recently had a toothache?
Yes☐ No☐ Has there been an accident involving teeth?
Yes☐ No☐ Has your child had a negative response to dental treatment?

Medical History

Yes☐ No☐ Is your child under the care of a physician?
If yes, please specify the condition:

_____

Yes☐ No☐ Taking any medication at present?
If yes, please specify the medications:

_____

Yes☐ No☐ Has your child ever been admitted to hospital?
Please list any operation or surgery your child has undergone:

_____

Please tick anything that applies to your child:

- ☐ Behavioural or communication problems?
- ☐ Rheumatic fever or heart disease?
- ☐ Hepatitis or jaundice?
- ☐ Any allergies including to drugs and medication?
- ☐ Bleeding disorders?
- ☐ Cerebral palsy or seizures?
- ☐ Asthma?
- ☐ Diabetes?
- ☐ Kidney disease?
- ☐ Other infectious diseases?
- ☐ Immunisations recommended by the N.S.W. Health department
- ☐ Further details:

_____

_____

Consent for Treatment:

Full name: _____

Address: _____

Occupation: _____ Telephone work: _____

I hereby certify to the best of my knowledge the foregoing information is correct. Because my child is a minor, I give my consent for their examination and treatment. Furthermore, I will be responsible for any financial obligations incurred for my child's treatment, bookkeeping fees and also for incidental costs incurred and/or legal fees necessary to recover the same. Major treatment such as treatment under general anaesthetic has to be paid in full no later than 8 days prior treatment, and the balance is payable within 3 days. A 50% cancellation fee is applicable for GA treatment if cancelled less than two working days prior to treatment.

I understand that for all other accounts, payment is requested on the day of treatment.

Person responsible for payment of account (Person responsible must sign at bottom of page).

Signed: _____ Date: _____

Method of Payment: Visa☐ Mastercard☐ Amex☐ Cash☐ Cheque☐