

Daniel Lu Pty Ltd. trading as Dentist On Queen ABN:87 073 861 248 97 Queen Street, St Mary's, NSW 2760 Ph: 02 9623 1261 E: info@dentistonqueen.com.au

Mr. Master, Mrs. Miss, Ms  Address: D.O.B: Suburb: Postcode: Mobile: Home: Email: Occupation: Email: Contact Number:  Contact Number:  Contact Number:  Contact Number:  How did you find us? Google/Signage/Internet /BUPA /Friends/Family: Name (so we can thank them)  Private Health Fund? YES or No. Which one?  Health Fund? YES or No. Which one?  MEDICAL HISTORY  Are you allergic to any that are listed below: YES or No. If yes please circle them and list any others that are not below.  Local Anesthetics Antibiotics Penicillin Latex Sulfa Drugs Sedatives or Sicepting pills  Aspirin Codeine Iodine Adrenalin Narcotics  Other:  PLEASE READ THE FOLLOWING LIST AND TICK THE CORRECT ANSWER   CARDIAC PACEMAKER  YES NO  CARDIAC PACEMAKER  YES NO  CARDIAC PACEMAKER  YES NO  LIVER DISEASE	First Name:	Surname:					
Suburb: Postcode:  Mobile: Home:  Cmail: Occupation:  Emergency Contact: Relationship: Contact Number:  MEDICAL HISTORY  Are you allergic to any that are listed below: YES or NO if yes please circle them and list any others that are not below.  Local Anesthetics Antibiotics Penicillin Latex Sulfa Drugs Sedatives or Sleeping pills  Aspirin Codeine Iodine Adrenalin Narcotics  Other:  PLEASE READ THE FOLLOWING LIST AND TICK THE CORRECT ANSWER   CARDIAC PACEMAKER  YES NO  CARDIAC PACEMAKER  PELEPSY  CARDIAC DEFIBILILATOR  RADIOTHERAPY OR CHEMOTHERAPY  HIGH BLOOD PRESSURE  LUVER DISEASE  LUVER DISEASE  LUVER DISEASE  LUVER DISEASE  LUVER DISEASE  LUVER DISEASE  HIGH CHOLESTEROL  HIV / AIDS (Please Circle if yes)  HIGH CHOLESTEROL  HIV / AIDS (Please Circle if yes)  HIGH CHOLESTEROL  STROKE  TUBERCULOSIS  SECESIVE BLEEDING PROBLEMS  ARTHRITIS  ARTHRITIS  SECESIVE BLEEDING PROBLEMS  ARTHRITIS  ARTHRITIS  DISEASE  LUVER DISEASE	Mr, Master,Mrs,Miss,Ms						
Mobile: Home: Occupation: Occu		D.O.B:	D.O.B:				
Emergency Contact: Relationship: Contact Number:  5P Name: Contact Number:  Health Fund; YES or No-Which one?  MEDICAL HISTORY  Are you allergic to any that are listed below: YES or No! If yes please circle them and list any others that are not below.  Local Anesthetics Antibiotics Penicillin Latex Suffa Drugs Sedatives or Sleeping pills  Aspirin Codeine Iodine Adrenalin Narcotics  Other:  PLEASE READ THE FOLLOWING LIST AND TICK THE CORRECT ANSWER   YES NO  CARDIAC PACEMAKER  YES NO PILEPSY  CARDIAC DEFIGRILLATOR  BADICTHERAPY OR CHEMOTHERAPY  CARDIAC DEFIGRILLATOR  HEART MURMUR  DIALYSIS  LIVER DISEASE  HEPATITIS A, B OR C (Please Circle If yes)  STROKE  TUBERCULLOSIS  EXCESSIVE BLEEDING PROBLEMS  ARTHRITS  SELEP APPLA  ASTHMA  DISEASE SUBJECT AND TICK THE CORRECT AND PAIN  J Please Circle Type 1 or 2)  J SUPFER HEADACHES OF JAW PAIN  J Please Circle Type 2 or 2)  SUPFER HEADACHES OF JAW PAIN  J Please Circle Type 1 or 2)  J SUPFER HEADACHES OF JAW PAIN  J Please Circle Type 1 or 2)  J SUPFER HEADACHES OF JAW PAIN  J Please Circle Type 1 or 2)  J SUPFER HEADACHES OF JAW PAIN  J Please Circle Type 1 or 2)  J CERTIFY THAN THE ABOVE Information is true and correct. I have read and understood the attached TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient Information Form and agree to be bound by those Terms and Conditions. I authorise the use of my personal information as dealth in the Privacy Att clause therein.  DO YOU DRINK ALCOHOL REGULARLY  J I L'EVED NOW MANY Standard TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient Information Form and ag	Suburb:	Postcode:	Postcode:				
Emergency Contact: Relationship: Contact Number:  3P Name: Contact Number:  Private Health Fund? YES or No- Which one? Health Fund patient ID e.g. 00, 01, 02  MEDICAL HISTORY  Are you allergic to any that are listed below: YES or No If yes please circle them and list any others that are not below.  Local Anesthetics Antibiotics Penicillin Latex Sulfa Drugs Sedatives or Sleeping pills  Aspirin Codeine Iodine Adrenalin Narcotics  Other:	Mobile:	Home:	Home:				
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Local Anesthetics Antibiotics Penicillin Latex Sulfa Drugs Sedatives or Sleeping pills			MEDIC	AL HISTORY			
Aspirin Codeine Iodine Adrenalin Narcotics  Other:	Are you allergic to any that are listed	below: YE	S or NO <i>if y</i>	es please circle them and list any others that are n	ot below.		
Aspirin Codeine Iodine Adrenalin Narcotics  Other:	Local Anesthetics A	ntibiotics	Penicillin	Latex Sulfa Drugs Sedatives or Sleeping pills			
PLEASE READ THE FOLLOWING LIST AND TICK THE CORRECT ANSWER   YES NO YES NO  CARDIAC PACEMAKER							
PLEASE READ THE FOLLOWING LIST AND TICK THE CORRECT ANSWER  YES NO YES NO  CARDIAC PACEMAKER EPILEPSY CARDIAC DEFIBRILLATOR RADIOTHERAPY OR CHEMOTHERAPY HEART MURMUR DIALYSIS LOW BLOOD PRESSURE LIVER DISEASE LOW BLOOD PRESSURE HEPATITIS A, B OR C (Please Circle if yes) HIGH BLOOD PRESSURE HIGH CHOLESTEROL HIV / AIDS (Please Circle if yes) STROKE STROKE TUBERCULOSIS ARTHRITIS SLEEP APNEA RHEUMATIC FEVER ASTHMA OSTEOPOROSIS DIABETES(If yes Circle type 1 or 2) SUFFER HEADACHES OR JAW PAIN JIF yes, how many weeks DO OR HAVE YOU EVER SMOKED If yes how many standard drinks a day?  PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING    I certify that the above information is true and correct. I have read and understood the attached TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient information Form and agree to be bound by those Terms and Conditions. Lautoriste the use of my personal information as details in the Privacy Act clause therein.  Guarantee: If I execute this agreement as the person responsible for payment on behalf of the Patient (Guardian), I guarantee the due and punctual payment of all monies under this agreement. This Guarantee and Indemnity shall constitute an unconditional and continuing guarantee and incennity and accordingly shall be irrevocable and remain in full force and effect until all of the monies owing to Daniel Lu Pty Ltd. trading as Dentist On Queen by the Patient and all obligation herein have been fully padis, saisfield and performed.    Name of Patient ( PLEASE PRINT)   Signature:    Daniel Lu Pty Ltd. trading as Dentist On Queen   Name:	A	spirin Co	deine lod	line Adrenalin Narcotics			
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YES NO   YES NO   YES NO   CARDIAC PACEMAKER   EPILEPSY   CARDIAC DEFIBRILATOR   RADIOTHERAPY OR CHEMOTHERAPY	PLEASE RE	ΔD THE FΩ	U OWING L	IST AND TICK THE CORRECT ANSWER			
CARDIAC PACEMAKER  CARDIAC DEFIBRILATOR  RADIOTHERAPY OR CHEMOTHERAPY  HEART MURMUR  HIGH BLOOD PRESSURE  LIVER DISEASE  LOW BLOOD PRESSURE  HEPATITIS A, B OR C (Please Circle if yes)  HIGH CHOLESTEROL  STROKE  TUBERCULOSIS  EXCESSIVE BLEEDING PROBLEMS  ARTHRITIS  SLEEP APNEA  ASTHMA  OSTEOPOROSIS  DIABETES(If yes Circle type 1 or 2)  If yes, how many weeks  DO or HAVE YOU EVER SMOKED  DO YOU DRINK ALCOHOL REGULARLY  If yes how many standard drinks a day?  PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING    I certify that the above information is true and correct. I have read and understood the attached TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient Information Form and agree to be bound by those Terms and Conditions. I authorise the use of my personal information as details in the Privacy Act clause therein.  Guarantee: If execute this agreement as the person responsible for payment on behalf of the Patient (Guardian), I guarantee the due and punctual payment of all monies under this agreement. This Guarantee and Indemnity shall constitute an unconditional and continuing guarantee the due and punctual payment of all monies under this agreement. This Guarantee and Indemnity shall constitute an unconditional and continuing guarantee and indemnity and accordingly shall be irrevocable and remain in full force and effect until all of the monies owing to Daniel Lu Pty Ltd. trading as Dentist On Queen by the Patient Add and punctual and continuing guarantee and indemnity and accordingly shall be irrevocable and remain in full core and effect until all of the monies owing to Daniel Lu Pty Ltd. trading as Dentist On Queen by the Patient Add and Photographs among other healthcare professionals for the purpose of improving dental treatment and Education  Name of Patient ( PLEASE PRINT)  Signature:  Date:  Date:	. 22/02 112			The state of the s			
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HEART MURMUR HIGH BLOOD PRESSURE LIVER DISEASE LOW BLOOD PRESSURE HEPATITIS A, B OR C (Please Circle if yes) HIGH CHOLESTEROL HIV / AIDS (Please Circle if yes)  STROKE TUBERCULOSIS EXCESSIVE BLEEDING PROBLEMS ARTHRITIS SLEEP APNEA ASTHMA OSTEOPOROSIS DIABETES(If yes Circle type 1 or 2) SUFFER HEADACHES or JAW PAIN If yes, how many weeks DO OR HAVE YOU EVER SMOKED If yes how many standard drinks a day?  PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING    Icertify that the above information is true and correct. I have read and understood the attached TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient Information Form and agree to be bound by those Terms and Conditions. I authorise the use of my personal information as details in the Privacy Act clause therein.   Guarantee: If I execute this agreement as the person responsible for payment on behalf of the Patient (Guardian), I guarantee the due and punctual payment of all monies under this agreement. This Guarantee and Indemnity shall constitute an unconditional and continuing guarantee and indemnity and accordingly shall be irrevocable and remain in full force and effect until all of the monies sowing to Daniel Lu Pty Ltd. trading as Dentist On Queen by the Patient and all obligation herein have been fully paid, satisfied and performed.   I hereby also consent the use of my records including dental and medical records, X-rays, Models, and Photographs among other healthcare professionals for the purpose of improving dental treatment and Education  Name of Patient (PLEASE PRINT) Signature:  Date:  Date:	1					-	
HIGH BLOOD PRESSURE  LOW BLOOD PRESSURE  HIGH CHOLESTEROL  HIV / AIDS (Please Circle if yes)  HIGH CHOLESTEROL  TUBERCULOSIS  EXCESSIVE BLEEDING PROBLEMS  ARTHRITIS  SLEEP APNEA  ASTHMA  OSTEOPOROSIS  DIABETES(If yes Circle type 1 or 2)  If female, ARE YOU PREGNANT  DO OF HAVE YOU EVER SMOKED  DO YOU DRINK ALCOHOL REGULARLY  PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING    Lertify that the above information is true and correct. I have read and understood the attached TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient information Form and agree to be bound by those Terms and Conditions. I authorise the use of my personal information as details in the Privacy Act clause therein.  Guarantee: If I execute this agreement as the person responsible for payment on behalf of the Patient (Guardian), I guarantee the due and punctual payment of all monies under this agreement. This Guarantee and Indemnity shall constitute an unconditional and continuing guarantee and indemnity and accordingly shall be irrevocable and remain in full force and effect until all of the monies owing to Daniel Lu Pty Ltd. trading as Dentist On Queen by the Patient (PLEASE PRINT)  Signature:  Date:  Date:  Date:  Date:					-	-	
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HIGH CHOLESTEROL  STROKE  TUBERCULOSIS  EXCESSIVE BLEEDING PROBLEMS  ARTHRITIS  SLEEP APNEA  ASTHMA  OSTEOPOROSIS  DIABETES(If yes Circle type 1 or 2)  If female, ARE YOU PREGNANT  DO OR HAVE YOU EVER SMOKED  DO YOU DRINK ALCOHOL REGULARLY  PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING					+	+	
STROKE  EXCESSIVE BLEEDING PROBLEMS  ARTHRITIS  SLEEP APNEA  RHEUMATIC FEVER  ASTHMA  DOSTEOPOROSIS  DIABETES(If yes Circle type 1 or 2)  If female, ARE YOU PREGNANT  DO OR HAVE YOU EVER SMOKED  DYOU DRINK ALCOHOL REGULARLY  If yes, how many weeks  DO YOU DRINK ALCOHOL REGULARLY  If yes how many a day?  PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING    I certify that the above information is true and correct. I have read and understood the attached TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient Information Form and agree to be bound by those Terms and Conditions. I authorise the use of my personal information as details in the Privacy Act clause therein.  Guarantee: If I execute this agreement as the person responsible for payment on behalf of the Patient (Guardian), I guarantee the due and punctual payment of all monies under this agreement. This Guarantee and Indemnity shall constitute an unconditional and continuing guarantee and indemnity and accordingly shall be irrevocable and remain in full force and effect until all of the monies owing to Daniel Lu Pty Ltd. trading as Dentist On Queen by the Patient and all obligation herein have been fully paid, satisfied and performed.  I hereby also consent the use of my records including dental and medical records, X-rays, Models, and Photographs among other healthcare professionals for the purpose of improving dental treatment and Education  Name of Patient (PLEASE PRINT)  Signature:  Date:  Date:					+	+ -	
EXCESSIVE BLEEDING PROBLEMS  SLEEP APNEA  ASTHMA  OSTEOPOROSIS  DIABETES(If yes Circle type 1 or 2)  If female, ARE YOU PREGNANT  DO OR HAVE YOU EVER SMOKED  If yes, how many weeks  DO YOU DRINK ALCOHOL REGULARLY  If yes how many standard drinks a day?  PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING    I certify that the above information is true and correct. I have read and understood the attached TERMS AND CONDITIONS which form part of and are intended to be read in conjunction with this Patient Information Form and agree to be bound by those Terms and Conditions. I authorise the use of my personal information as details in the Privacy Act clause therein.  Guarantee: If I execute this agreement as the person responsible for payment on behalf of the Patient (Guardian), I guarantee the due and punctual payment of all monies under this agreement. This Guarantee and Indemnity shall constitute an unconditional and continuing guarantee and indemnity and accordingly shall be irrevocable and remain in full force and effect until all of the monies owing to Daniel Lu Pty Ltd. trading as Dentist On Queen by the Patient and all obligation herein have been fully paid, satisfied and performed.  I hereby also consent the use of my records including dental and medical records, X-rays, Models, and Photographs among other healthcare professionals for the purpose of improving dental treatment and Education  Name of Patient (PLEASE PRINT)  Signature:  Date:  Date:					-	+	
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