Future Care Mobile Dental Services

Adult Consent Form

Centre Name/Location			
First Name		Last Name	
Date of Birth (DD/MM/YY)		Phone number	
Home address			
Email address			
Emergency contact name		Emergency contact number	

Payment Options

You are welcome to pay at the time of your consultation via cash or credit card. Alternatively please provide your payment details below. No amounts will be debited from your card until after your consultation.

Pay via credit card

Name on credit card	
Credit card number	
Expiry date (MM/YY)	
CCV	
Amount payable	

Pay via direct deposit

Our account name	Future Skills Network Group
BSB	012 110
Account Number	295 987 518
Please put your full name as the reference	

Pay via PayPal

To pay via PayPal, download the PayPal app or log onto the PayPal website. When asked, our email address is accounts@fcmdental.com.au. Follow the prompts from there to pay $99 for the service.

Signature : _____ Date: ___/___/____

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Medical History Questionnaire

First Name		Last Name	

Please provide details or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/Current medical conditions		
Are you receiving any medical treatment at present?	Y / N	Details
Have you had any serious or long standing illness?	Y / N	Details
Have you ever been hospitalised?	Y / N	Details

Please indicate if you have EVER had any of the following:

Any heart complaint/treatment	Y / N	Any nervous system disorder	Y / N
Rheumatic fever or heart valve surgery	Y / N	Asthma/bronchitis/lung conditions	Y / N
High or low blood pressure	Y / N	Radiation therapy / chemotherapy	Y / N
Blood disorders / bleeding disorders	Y / N	Thyroid disease	Y / N
Epilepsy	Y / N	Hepatitis, jaundice or liver disease	Y / N
Diabetes	Y / N	Treatment for any form of cancer	Y / N
Familial diseases	Y / N	Transplanted organ or bone marrow	Y / N
Infectious disease (measles/chicken pox), especially in the last three weeks	Y / N	Kidney conditions	Y / N
Tuberculosis	Y / N	Do you smoke?	Y / N
Details if yes to any of the above:			
Current medications			
Allergies (e.g. latex, penicillin, etc):			

I agree that the above is a true and accurate record. Please note, this form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments. Please see our website for our privacy statement.

Signature : _____ Date: ___/___/____