**ALL INFORMATION IS CONFIDENTIAL!**



**Please fill out both sides of this form and return to reception; When you sign the bottom of this page you agree that you are happy for your information to be used by any dentist/staff member in accordance with your treatment.**

Title\_\_\_\_\_\_First name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suburb:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please tick box if you do not wish to receive newsletter

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency/secondary contact name and number (Please provide Guardian if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have private insurance with dental cover, if so which fund? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last dental visit and x-rays?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies to any drugs, medicines or latex? YES /NO If yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please state **ALL** medications you are currently taking including bisphosphonates and blood thinners:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you or have you ever suffered from any of the following? If so, please elaborate in the space provided.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **RHEUMATIC FEVER** | **YES** | **NO** | **HEART PROBLEMS YES** | | **NO** | **ANAEMIA YES NO** |
| **TUBERCULOSIS** | **YES** | **NO** | **HEART VALVE (PROSTHETIC) YES** | | **NO** | **DIABETES YES NO** |
| **TUMOUR HISTORY** | **YES** | **NO** | **CARDIAC PACEMAKER** | **YES** | **NO** | **ARTHRITIS YES NO** |
| **CHEMO THERAPY** | **YES** | **NO** | **HEPATITIS A, B OR C** | **YES** | **NO** | **ASTHMA YES NO** |
| **RADIATION THERAPY** | **YES** | **NO** | **HIV/AIDS** | **YES** | **NO** | **EPILEPSY YES NO** |
| **HIGH BLOOD PRESSURE** | **YES** | **NO** | **KIDNEY DISEASE** | **YES** | **NO** | **OTHER MAJOR SURGERY** |
| **SINUS PROBLEMS** | **YES** | **NO** | **LIVER DISEASE** | **YES** | **NO** | **OR CONDITIONS:\_\_\_\_\_\_** |
| **BLEEDING DISORDERS** | **YES** | **NO** | **OSTEOPOROSIS** | **YES** | **NO** | **SMOKER**​​ **YES NO** |
| **FITS OR SEIZURES** | **YES** | **NO** | **PROSTHETIC JOINTS** | **YES** | **NO** | **PREGNANT** ​ ​ **YES NO** |

**BY SIGNING THIS FORM I UNDERSTAND ALL ACCOUNTS ARE TO BE PAID ON THE DAY OF TREATMENT IN FULL**

**Signed**:​ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**​ :​ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **P.T.O and fill in reverse form**

**ALL INFORMATION IS CONFIDENTIAL!**

**WELCOME TO SMILE HOUSE**

**We endeavour to provide a service to meet all your dental requirements, to assist us in this, we ask you to please fill out the**

**questionnaire below:**

* **What is the main reason for your visit today?**

**…………………………………………………………………………..**

* **Are you happy with the appearance of your**

**teeth/smile? Yes / No...........................................**

* **Please list any dental concerns you may have:**

**…………………………………………………………………………….**

**……………………………………………………………………………..**

**………………………………………………………………………………**

**………………………………………………………………………………**

**Please circle any other the following services or treatment options you may wish to discuss with our dentist:**

* **Teeth whitening**
* **Orthodontics or straightening of the teeth**
* **Cosmetic treatment to enhance your smile**
* **Replacing missing teeth**
* **Preventative dentistry**