Welcome to Smiles Are Us!

We strive to provide you with the highest standard of dental care. Completing the following questionnaire will help our dental team plan your care properly. If you are unsure about anything, please ask our staff for assistance.

1. Personal Information

Title: ………… Given Name: ……………………………..…. Surname: ………….…………………….

Date of Birth: ……………………… Preferred Name: …………………………………………………

Address: …………………………………………………………………………..…. Postcode: ………….

Phone Home: ……………………… Work: ……………………. Mobile: ……………………………..

Email: ……………………………………………………………………………………………………

Occupation: ……………………………………………….……. Company: …..……………………………

Name of Private Health Fund: ……………………………………………………………………………

Membership Number: …………………………………………….…. Patient ID number: ……………….

Personal responsible for payment: ……………………………………………………………………….

Emergency contact: ……………………………………………… Contact relation: …………………….

Emergency contact number: ………………………………………………………………………………...

2. Dental Information

What is your dental concern or main reason for attending today?

……

Are you aware of any dental problems you may have or wish to discuss?

☐ Toothache
☐ Cracked or fractured fillings
☐ Appearance of teeth
☐ Unsatisfactory denture
☐ Orthodontics
☐ Wisdom teeth
☐ Difficulty eating or chewing
☐ Sensitive teeth
☐ Lost fillings/cavities
☐ Colour of teeth
☐ Grinding/clenching teeth
☐ Receding gums
☐ Loose or mobile teeth
☐ Headaches
☐ Jaw Pain
☐ Worn down teeth
☐ Missing teeth
☐ Dry mouth
☐ Bleeding gums
☐ Bad breath
☐ Sleep apnoea

Other: Please specify: ……………………………………………………………………………………

How long since your last dental visit? …………………………………………………………………………...

How often do you have dental examinations? ………………………………………………………………….

When did you last have dental radiographs? ……………………………………………………………..

3. Dental Services

Are you interested in any of the following?

- ☐ Cosmetic dental options
- ☐ Teeth whitening
- ☐ Teeth cleaning
- ☐ CEREC restorations
- ☐ White fillings
- ☐ Amalgam removal
- ☐ Porcelain crowns
- ☐ Porcelain veneers
- ☐ Porcelain inlays/onlays
- ☐ Invisalign clear braces
- ☐ Smilefast braces
- ☐ Orthodontics
- ☐ Anti-wrinkle treatment
- ☐ Skin care treatment
- ☐ Gum care
- ☐ Dental implants
- ☐ Replacing missing teeth
- ☐ Nightguards
- ☐ Jaw pain treatment
- ☐ Sleep apnoea treatment
- ☐ Anti-snoring treatment

On a scale of 1 to 10, how would you rate your smile? …………………………..

If you could change one thing about your smile what would it be?

……

…….

Have you ever had any reaction or complication following dental treatment in the past?

……........

Is there anything else the dentist or hygienist should be aware of?

…….........

……..

Is there a reason you left your last dental practice?

……..

………..……….

smiles are us

4. Medical Information

Please tick any of the following conditions that apply now or in the past:

- ☐ Abnormal bleeding
- ☐ Artificial heart valve
- ☐ Arthritis
- ☐ Asthma
- ☐ Bisphosphonates i.e. Fosamax
- Blood pressure ☐ High ☐ Low
- ☐ Cardiac surgery/Pacemaker
- ☐ Cancer
- ☐ Depression
- Diabetes ☐ Type 1 ☐ Type 2
- ☐ Do you snore or experience restless sleep
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart condition
- Hepatitis ☐ A ☐ B ☐ C
- ☐ HIV positive
- ☐ Nervous condition
- ☐ Pregnant Due date: ……………….
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Smoker How many per day: ……….
- ☐ Thyroid problem
- ☐ Warfarin medication

Other: ……………………………………………………………………………………………………

Joint replacement: ……………………………………………………………………………………..

Allergies: ☐ Penicillin ☐ Latex

Other (specify all allergies): ……………………………………………………………………………..

Are you taking any medications?

If yes please list: ………………………………………………………………………………………..

…………………………………………………………………………………………………….….

Name of your medical GP doctor: ……………………………………………………………………

How did you find out about Smiles Are Us:

- ☐ Health Fund
- ☐ Website
- ☐ Google
- ☐ Street Signage
- ☐ Facebook
- ☐ Other: ……………………………………… …
- ☐ Personal referral: …………………………………………………………………………………

5. Your Health Information and Our Privacy Policy

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed. The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2. We may disclose your health information to other health care professionals, including specialists we may refer you to, or require it from them if, in our judgment, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. I understand and accept that Smiles Are Us requires a minimum of 48 hours notice for cancelling or rescheduling appointments. Appointments not attended or cancelled without 48 hours notice, may be charged a fee.

If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice. Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way

I have read and understand the Smiles Are Us privacy policy. I have provided accurate information about myself and my health.

Signature: ……………………………………………………….. Date: ……………………………….

Dentist signature: ……………………………………………….. Date: ……………………………….