



Welcome to Smiles On Grenfell!

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: Suburb: Postcode:
Phone Home: Mobile:
Email:
Occupation: Company:
Name of Private Health Fund:
Membership Number: Patient ID number:
Person responsible for payment:
Emergency contact: Contact relation:
Emergency contact number:

2. Dental Information

What is your dental concern or main reason for attending today?
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Are you aware of any dental problems you may have or wish to discuss?

- Checkboxes for: Toothache, Sensitive teeth, Jaw Pain, Cracked or fractured fillings, Lost fillings/cavities, Worn down teeth, Appearance of teeth, Colour of teeth, Missing teeth, Unsatisfactory denture, Grinding/clenching teeth, Dry mouth, Orthodontics, Receding gums, Bleeding gums, Wisdom teeth, Loose or mobile teeth, Bad breath, Difficulty eating or chewing, Headaches, 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, CEREC restorations, Porcelain crowns, Invisalign clear braces, Anti-wrinkle treatment, Replacing missing teeth, Jaw pain treatment, Teeth whitening, White fillings, Porcelain veneers, Orthodontics, Nightguards, Dental implants, Sleep apnoea treatment, Teeth cleaning, Amalgam removal, Porcelain inlays/onlays, Myobrace, Gum care, All on 4 implants, 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?

4. Medical Information

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

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

- | | |
|---|---|
| <input type="checkbox"/> Health Fund | <input type="checkbox"/> Street Signage |
| <input type="checkbox"/> Website | <input type="checkbox"/> Facebook |
| <input type="checkbox"/> Google | <input type="checkbox"/> Other: |
| <input type="checkbox"/> 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 on Grenfell 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 On Grenfell privacy policy. I have provided accurate information about myself and my health.

Signature: Date:

Dentist signature: Date:

