Incredible Smiles

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WELCOME TO OUR PRACTICE

We appreciate the confidence you place in us. To assist us in providing the best possible care please complete the following questionnaire. The information provided on this form is important to your dental health and will be regarded as confidential.

Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: _____

Parent/Guardians name: (if under 18) _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Postal Address: (if different from above) _____

Suburb: _____ State: _____ Postcode: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Mobile: _____

Email Address: _____

Occupation: _____

Emergency Contact: _____ Relationship to you: _____ Phone: _____

Private Health Fund: _____ Member No: _____ IRN: _____
Medicare No._____ Reference No._____ Expiry._____
Pension Card Type._____ Pension Card number _____

GP/Medical Clinic: _____ Phone: ( ) _____

Person responsible for the account: _____ Relationship to you: _____

Address: (if different from above) _____ Phone: _____

How were you referred to our practice:

Social Media	Google/Reviews	Website	Family	Friend	Staff
Local/Drive By	SADS	Event	BNI	Specialist/GP	Other

(If circled Family/Friend- What is their name) _____

DENTAL HISTORY

	Yes	No		Yes	No
Does your jaw click or hurt?			Do you think you have occasional bad breath?		
Do your gums ever bleed when you brush your teeth?			Do you feel you grind your teeth?		
Have you ever had orthodontic treatment?			Do you experience sensitivity with hot/cold?		
Do you wear a night guard?			Do you bite your lips or cheeks often?		
Have you ever had gum disease?			Does floss ever tear between your teeth?		
Have you ever had your bite adjusted?			Do you smoke?		
Does food get caught between your teeth?			Do your teeth ever hurt if you bite hard?		
Do you have difficulty opening or closing your mouth?			Any pain in the joint, ear or side of face?		

What is the reason for your dental visit today? _____

When was your last dental visit?_____Last dental cleaning?_____Last full mouth X- rays?_____

What was done at your last dental visit? _____

Do you feel nervous about having dental treatment? (If yes, Please explain): _____

Have you ever had an upsetting dental visit? Tell us more _____

Is there anything else about your dental condition that you wish for us to know? _____

Medical History

	Yes	No		Yes	No
Diabetes			Asthma		
Heart Murmur			High Blood Pressure		
Mitral Valve Prolapse			Latex sensitivity		
Rheumatic Fever			Hepatitis A, B or C (Please specify)		
Kidney problems			HIV/Aids		
Radiation Therapy			Liver disease		
Tumours			Chemotherapy		
Bloods Transfusions			Tuberculosis		
Haemophilia			Excessive Bleeding		
Epilepsy/Seizures			Excessive Bruising		
Blood disorders			Anaemia		
Artificial joint/Valve			Psychiatrist care		
Heart Related issues			Pacemaker or Surgery		

Are you allergic to any medications or drugs? Yes / No (If yes, please specify)_____

Are you taking any medication? Yes / No (If yes, please list)_____

Have you been a patient in Hospital in the last 5 years? Yes / No (If yes, please specify)_____

Have you ever taken any of the following 'Bisphosphonate' medication? (please circle)

Fosamax	Didronel	Didrocal	Aredia	Skelid	Actonel	Zometa

Women, are you pregnant? Yes/No / Maybe If yes, how many weeks? _____ Are you Nursing? Yes / No

Do you have any disease, condition or problem not listed? Yes / No (If yes, please specify) _____

Do you require antibiotic cover for dental treatment? Yes / No (If yes, please specify) _____

CONSENT OF TREATMENT

I have answered all questions honestly and to the best of my knowledge. If further information is needed, you have my permission to ask the prospective health care provider or agency, who may release such information to you. I will notify the Dentist of any changes in my health or medication. I authorise the Dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the Dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I authorise the Dentist and staff to perform and administer treatment, medication, and therapy that may be indicated. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

Patient/Parent/Guardian's Signature: _____ Date: _____

PAYMENT TERMS AND CONDITIONS

I understand that payment for dental services provided at this practice to me and my dependents are due and payable at the time services are rendered, unless financial or other approved arrangements have been made. In the event the payments are not received by agreed upon dates, I understand that a billing charge may be added to my account. I agree to be responsible for payment of all services rendered to me and my dependents. I authorise that this data may be reviewed by team members of the dental practice.

I UNDERSTAND THE PRACTICE REQUIRES AT LEAST 24 HOURS NOTICE TO CANCEL MY APPOINTMENT OR A CANCELLATION FEE MAY APPLY. I AM AWARE THAT FULL PAYMENT IS REQUIRED AT THE TIME OF THE APPOINTMENT. WE PROVIDE A COURTESY TO ALL OUR PATIENTS THAT OFFERS A REMINDER SERVICE IF WE HAVE NOT SEEN YOU IN OVER 6 MONTHS.

Patient/Parent/Guardian's Signature: _____ Date: _____