Smiles First Dental
HELPING LOCALS SMILE

Welcome to Smiles First Dental, To provide you treatment with the highest standard, we need to know about the state of your health and medical history. In accordance with Privacy Amendment Act 2004 and Health records and informations Act 2002, all information will be treated in the strictest confidence.

Title: ☐ Dr ☐Mr ☐Mrs ☐Ms ☐Miss ☐Master ☐Other

First Name:……..

Surname:……

Date of Birth:……/……/……..

Address:……..

……..

Post code:……

Home Phone:……..

Mobile Phone:……

Work Phone:……..

Email :……..

Occupation:……

Emergency Contact:

Name:……

Contact Number……..

Are you in a Private Health fund? Yes ☐ No ☐

Which do you belong?……

Member Number:……

Patient reference number……

Is another member of your family a patient at Smiles First Dental?

Yes ☐ Name/s:……

To ensure treatment we provide you is compatible with your present state of health, please answer the following:

Are you, at present receiving medical treatment?

Yes ☐ No ☐

Details……

……

Please list any medications that you are taking and how often:

……

……

Please indicate if you have had or have been treated for any of the following: **YES**

Rheumatic fever	☐
Circulatory problems	☐
Radiation Treatment	☐
Blood pressure changes	☐
Anaemia or other blood issues	☐
Do you bleed easily	☐
Excessive brusing	☐
Diabetes Type……..	☐
Hepatitis Type……..	☐
Epilepsy	☐
Thyroid Disease	☐
Tuberculosis	☐
Asthma	☐
Gastric Ulcer	☐
Liver or Kidney problems	☐
Tumour History?	☐
Sinus Issues?	☐
Bone disorders or issues?	☐
Allergies to anaesthetics?	☐
Allergies to Penicillin?	☐
Allergies to Medications?	☐
Allergies to Latex?	☐
Do you smoke?	☐

Details……

……

……

Are you Pregnant? Yes ☐ Due Date……

When did you last see a dentist?……

When were your last dental X-rays taken?

Less than a year ? ☐ More than 1 year? ☐

What is your main reason for the visit today?

……

……

Please see next page

Please indicate if you have had any of the following:	**YES**
Does your jaw click or cause pain?	☐
Do you feel you grind your teeth ?	☐
Have you had orthodontic treatment?	☐
Do you wear an occlusal splint?	☐
Do you have bad breath?	☐
Do notice your gums bleed when you brush?	☐
Does floss tear between your teeth?	☐
Do you experience hot/cold sensitivity?	☐
Do you snore? (or have been told you do?)	☐
If yes, have you been diagnosed with sleep apnoea?	☐

Is there anything else you feel we should know?

……

……

……

How did you hear about us?

- ☐ Friend/Family referral
- ☐ Website
- ☐ Signage/driving past
- ☐ Google
- ☐ smile.com.au
- ☐ Other ……..

Please select your preferred Method(s) of communication for 6 monthly check up recalls:

- ☐ SMS
- ☐ Phone Call
- ☐ Email
- ☐ Letter

PLEASE NOTE PAYMENT IS REQUIRED ON THE DAY FOLLOWING YOUR TREATMENT.
NO ACCOUNTS WILL BE ISSUED.

Signature_____Date: / /