SMILESSENCE

YOUR DETAILS (Please print clearly)

Title. . . . . .Surname……Given Names……...……..

Preferred name.....

Date of birth……..……..... Gender: □ Male □ Female

Address……..…

Suburb…….....State……Postcode…....…..…

Telephone:.(H)…….(M)……

(B)……Occupation.....

Email……..

NEXT OF KIN/PERSON TO CONTACT IN EMERGENCY

Name:……..Relationship to patient……..

Contact number:.....

PRIVATE HEALTH INSURANCE

Do you have Private Health Insurance *with Dental cover*? □ Yes □ No

Fund Name.....Line Ref No.....

Person responsible for fees (if not self).....…….....…….

Are you happy for us to confirm your appointments via SMS on your mobile? □ Yes □ No

If not, would you prefer: □ Email □ Phone

How did you hear about us?

☐ Advertisement ☐ Web search ☐ Street signage ☐ Other

☐ Referral/recommendation Referer's name:.....

YOUR MEDICAL HISTORY

Please tick "Yes" if you have now, or have had in the past, any of the following:

Heart condition	□ Yes □ No	Muscle, bone, joint problems	□ Yes □ No
Rheumatic fever	□ Yes □ No	Immune system problems	□ Yes □ No
High blood pressure	□ Yes □ No	Gastrointestinal problems	□ Yes □ No
Bleeding problems	□ Yes □ No	Urogenital problems	□ Yes □ No
Respiratory problems	□ Yes □ No	Liver problems	□ Yes □ No
Nervous system problems	□ Yes □ No	Cancer	□ Yes □ No
Thyroid problems	□ Yes □ No	Pregnancy	□ Yes □ No
Diabetes	□ Yes □ No	Smoking	□ Yes □ No
Infectious diseases	□ Yes □ No	Alcohol	□ Yes □ No
Osteoporosis	□ Yes □ No	Radiation Treatment	□ Yes □ No

Allergies –	Penicillin	□ Yes □ No
	Latex	□ Yes □ No
	Medications	□ Yes □ No .....
	Other	□ Yes □ No .....

Please list any **current medications**:.....

.....

Have you ever taken any of the following medications? Zometa™, Pamidronate™,

Bonefos™, Actonel™, Fosamax™ □ Yes □No .....

Hospital admissions……...

Other medical history..……..…

FAMILY DOCTOR'S DETAILS

Doctor's Name……...

Address…….....……..

Telephone……...

Dental History

What is your main reason for your visit: ……

……

Have you had any of the following?

Does your jaw click or hurt? □ Yes

Do you feel you clench or grind your teeth? □ Yes

Have you ever had orthodontic treatment □ Yes

Have you ever had Gum Disease? □ Yes

Have you ever had your bite adjusted? □ Yes

Do you think you have occasional bad breath? □ Yes

Do your gums ever bleed when you brush your teeth? □ Yes

Do you have sensitivity with hot or cold? □ Yes

Does floss tear or catch between your teeth? □ Yes

Does food jet jammed between your teeth? □ Yes

Do your teeth ever hurt when you bite hard? □ Yes

How often do you brush?

□ More than 2X daily □ 2X daily □ Once daily □Less than once daily

How often do you floss?

□ 2X daily □Daily □Less than 1X daily □ Not Flossing

How long has it been since your last dental visit? .....

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

Previous dental x-rays were taken:

□ Less than a year ago □ Longer than a year ago

Patient Signature: .....**Date:**.....

Parent/Responsible party's Signature:.....

Relationship to patient: .....