refresh dental spa
excellence in dental & facial aesthetics

CONFIDENTIAL INFORMATION

Surname: _____ First Name: _____Title_____

Date of Birth: _____Preferred name: _____

Home Address: _____

Postal Address: _____

Home Ph: _____ Work Ph: _____

Mobile: _____ Email: _____

Your preferred method of contact: Email /Home Ph / Work Ph / Mobile (please circle)

Occupation: _____Employer:_____

Emergency Contact Name: _____Ph:_____

Private Health Fund: No / Yes, which fund? _____

How did you discover our Practice? _____ When was your last dental visit?_____

Would you like to be notified of special offers and promotions? Yes / No

Please tick all appropriate concerns

- ☐ Toothache
- ☐ Sensitive teeth (hot/cold)
- ☐ Loosening teeth
- ☐ Missing teeth
- ☐ Denture
- ☐ Bleeding gums
- ☐ Broken/chipped teeth
- ☐ Lost filling/ cavity
- ☐ Issues with jaw (TMJ)

Other_____

- How would you rate the following out of 10? (10 being the best)

Shape of teeth:	1	2	3	4	5	6	7	8	9	10
Shade of teeth:	1	2	3	4	5	6	7	8	9	10
Position of teeth:	1	2	3	4	5	6	7	8	9	10

If there is something that you could do to get closer to a 10, would you be interested? And what would you most like to improve? _____

- Have you ever had any of the following treatments? (please circle)

Botox Dysport Dermal Filler Cosmetic Tattooing Collagen Induction Therapy

- How would you rate the following out of 10? (10 being the best)

Health of skin:	1	2	3	4	5	6	7	8	9	10
Appearance of skin:	1	2	3	4	5	6	7	8	9	10

If there is something that you could do to get closer to a 10, would you be interested?

_____

Would you be interested in free facial mapping as part of your dental exam? Yes / No

CONFIDENTIAL MEDICAL HISTORY

Do you currently have, or have you ever been treated for any of the following conditions?

	YES	NO		YES	NO
Steroid Therapy			Nervous Condition		
Rheumatic Fever			Tuberculosis		
Epilepsy			Thyroid Disease		
Asthma			Radiation Therapy		
Diabetes			High or Low Blood Pressure (please circle)		
Heart Valve Disorder			Transplanted Organ or Bone Marrow		
Stroke			Kidney Disease		
Heart Murmur			Excessive Bleeding		
Cardiac Pacemaker			Hepatitis A B C (please circle)		
Eating Disorder			Liver Disease		
Heart Complaint or Surgery eg Bypass Operation			Blood Disorder		
Stomach or Digestive Condition (e.g. Reflux)			Confirmed/Suspected contact with HIV/AIDS Virus		
Anaemia			Bronchitis. Emphysema or other Lung Disease		
Cancer			Prosthetic Implant (e.g. Prosthetic Hip or Knee)		

Name of Medical Practitioner: _____

Do you have or have you ever had bone disease? _____

(e.g. Osteoporosis, Paget's Disease, Multiple Myeloma, Cancer which spread to bones)

Are you taking or have you taken in the past **Bisphosphonate** medications? _____

(e.g. Alendronate, Risedronate, Pmidronate, Zoledronate, Tiludronate, Etidronate, Clodronate, Fosamax, Actonel, Zometa, Aredia, Pamisol)

- Are you currently receiving any medical treatment? Yes / No
- If yes, please advise: _____
- Are you currently taking any medications? Yes / No
- If yes, please list: _____
- Do you have any known allergies? Yes / No

  If yes, please list: _____
- Have you had an unfavourable reaction to local anaesthetics? Yes / No
- Do you Smoke? Yes / No / Socially
- For female patients, are you pregnant Yes / No / Unsure

All information will be treated with complete professional confidentiality

Do you consent to sharing necessary records with dental specialists? Yes / No

Dentist Signature: _____ **Date:** _____

We request and expect payment at the time of treatment.
For your convenience we accept Cash, Cheque, Eftpos, Visa, MasterCard and Amex.
In order to avoid a broken / failure to attend appointment fee, we require 24 hours' notice to reschedule an appointment. By signing this form you agree to these terms and conditions.

Signature: _____ **Date:** _____