

### 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**

- |   |  |
|---|--|
| <input type="checkbox"/> Toothache                  | <input type="checkbox"/> Bleeding gums         |
| <input type="checkbox"/> Sensitive teeth (hot/cold) | <input type="checkbox"/> Broken/chipped teeth  |
| <input type="checkbox"/> Loosening teeth            | <input type="checkbox"/> Lost filling/ cavity  |
| <input type="checkbox"/> Missing teeth              | <input type="checkbox"/> Issues with jaw (TMJ) |
| <input type="checkbox"/> Denture                    |  |

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:** \_\_\_\_\_