We ask you to provide the following pre-treatment information. The information we collect enables us to care for you better.
We value your privacy, so all details will be kept strictly confidential.

YOUR DETAILS

Please Circle
Title: Mr Mrs Ms Miss Dr (Other ....) Surname: ....

First Name: .... Preferred Name: ....

Date of Birth: ....

Home Address: ....

.... Post Code:...................

Home Phone: .... Mobile Phone: ....

Email: ....

Please tick box if you do **NOT** wish to receive special promotions and communications via email ☐

Business Contact

Your Occupation: .... Work Phone: ....

Business Name: ....

Business Address: ....

Emergency Contact

Name: .... Contact No: ....

Relationship to you: ....

DENTAL INFORMATION

What is the purpose of your visit today?

....

Have you had any problems with past dental treatment? Yes ☐ No ☐

If yes, please explain: ....

....

To whom shall we make your accounts payable? ....

How did you hear about our practice? ....

Do you belong to a Health Fund? Yes ☐ No ☐ Which one? ....

Please Turn Over

CONFIDENTIAL HEALTH INFORMATION

Have you had any significant medical problems in the last year? Yes ☐ No ☐

If yes, please specify: ....

Name and address of your general Medical Doctor: ....

.... Phone No: ....

When did you last visit your doctor? ....

Do you currently, or have you ever suffered from any of the following conditions?

Please tick as appropriate.	**Yes**	**No**		**Yes**	**No**
Arthritis	☐	☐	Stroke or Heart Attack	☐	☐
Rheumatic Fever	☐	☐	Heart Trouble	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Diabetes	☐	☐	Excessive Bleeding	☐	☐
Epilepsy or fits	☐	☐	H or L Blood Pressure	☐	☐
Angina	☐	☐	Anaemia	☐	☐
Disorder of blood or immune system	☐	☐	Tuberculosis	☐	☐
Hepatitis or liver disorder	☐	☐	Osteoporosis	☐	☐

Do you have any allergies? (e.g. penicillin, codeine, nickel, latex) Yes ☐ No ☐

Please Specify: ....

Do you take any prescribed drugs, tablets, medicines or creams? Yes ☐ No ☐

Please Specify: ....

Have you ever taken or been given medication for Osteoponeia or Osteoporosis? Yes ☐ No ☐

Do you take any recreational drugs? Yes ☐ No ☐

Have you had any adverse reactions to any treatments or medications? Yes ☐ No ☐

Please Specify: ....

Have you had radiation treatment to the head or neck? Yes ☐ No ☐

When? ....

Do you have a heart murmur, or artificial heart valve? Yes ☐ No ☐

Do you have any prosthetic body parts? (e.g. artificial hip or knee joint) Yes ☐ No ☐

List: ....

Ladies, are you pregnant or family planning? Yes ☐ No ☐ If so, how many weeks? ....

Do you smoke? Yes ☐ No ☐ If so, how many? ....

I have read and understood the Smile Solutions Privacy Policy.

I understand that payment is required on the day of treatment.
My preferred method of payment is:

Cash ☐ EFTPOS ☐ Bankcard ☐ Mastercard ☐ Visa ☐

Signature: .... Date: ....

Failure to give 24 hours notice for appointment changes may incur a cancellation fee.