CARING 4 SMILES dental group-New Patient Questionnaire

Welcome to our dental practice. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to have the healthy teeth and attractive smile you want and deserve. These questions provide the legally required information the Dentist needs prior to any dental treatment. EVERY new patient MUST complete both pages of this registration. ALL your details will be treated as CONFIDENTIAL

ABOUT YOU:

SURNAME:____ **PROF/DR/MR/MAST/MRS/MISS/MS**

GIVEN NAMES:_______________________________________ **DATE OF BIRTH:**___________________

RESIDENTIAL ADDRESS:____

POSTAL ADDRESS:____ **POST CODE:**_______

CONTACT NUMBERS: Home:________________**Work:**______________ **Mobile:**__________________

Email:____

(Note: Our practice will not SPAM you or share email addresses with third parties. We will email you with your appointment reminders and our quarterly newsletter.)

WHEN MAKING CONTACT do you prefer: EMAIL **or** PHONE CALL **to:** HOME/WORK/MOBILE

OCCUPATION: _______________________ **BUSINESS/EMPLOYER NAME**:______________________

HOW DID YOU FIND OUT ABOUT US?_____________________**"Thank you for joining our practice."**

WHO CAN WE THANK FOR REFERRING YOU:____

NEXT OF KIN / EMERGENCY CONTACT: _________________________**PHONE**__________________

THEIR RELATIONSHIP TO YOU:____

DENTAL HISTORY:

When was your last dental visit? ____________________ **Are you afraid of the dentist?** YES/NO

Is your visit to the dentist today an emergency? YES/NO **Reason for Visit:**__________________________

Do you experience bad breath? YES/ NO **Do your gums bleed?** YES/NO

Have you ever experienced any pain in your jaw/joints? YES/NO/LEFT/RIGHT/ BOTH/ CLICKY JAW

Do you clench and grind your teeth? YES/NO **Have you ever chipped a tooth?** YES/NO

Have you ever thought about improving your Smile? YES/NO **In what way?**_________________________

Is there anything about your Smile you would like changed? YES/NO_______________________________

Caring 4 Smiles has a PREVENTIVE CARE plan. Would you like to know more? YES/NO

Bad breath and bleeding gums are an indication of advancing gum disease. The Medical research has established a direct connection between gum disease and heart disease. Pregnant mothers must have comprehensive oral care to prevent damage to the unborn child

MEDICAL HISTORY:

Name of your Medical Practitioner:______________________________**Phone:**_______________________

Address:____

Are you receiving any medical treatment at the present time? YES/NO **for:**__________________________
____

Do you have any bleeding disorders: YES/NO **Please specify:**____________________________________

Do you take Aspirin /Warfarin **or any blood thinning medication?** YES/NO **List:**_______________________

Please list any medication/drugs you are currently taking:____

Do you have any allergies to an: MEDICATION/DRUGS **or** METALS? YES/NO
Please list:____

Have you ever had an allergic reaction to: LOCAL/GENERAL ANAESTHETIC? YES/NO
Please Explain: ____

Are you wearing an artificial or prosthetic joint or had recent major surgery? YES/NO
Please Specify:____

Have you ever had a test for: HEPATITIS/HIV/AIDS? YES/NO **Result:** POSITIVE/NEGATIVE

Do you smoke? YES/NO **How many a day?** _______ **How long have you been smoking?**________________

<u>Women</u>: Are you currently pregnant? YES/NO **How many weeks?**_____________ **Due Date**:__________

Have you ever had any of the following? (Please tick ONLY if the answer is YES)

☒ Rheumatic fever ☒ Heart condition n ☒ High blood pressure ☒ Asthma
☒ Arthritis ☒ Depressive illness ☒ Severe headaches ☒ Epilepsy
☒ Anaemia ☒ Diabetes ☒ Kidney disease ☒ Cold sores
☒ Gastric problems ☒ Drug dependence ☒ Hepatitis – A / B / C ☒ Cancer
☒ Bronchitis ☒ Liver disorder ☒ Anxiety ☒ TB

Are there any other aspects concerning your health you think your dentist should know about?
____

PAYMENT TERMS:

Payment is required at the time of your dental visit unless special arrangements have been made prior to your visit. Method of payment: ☒ MasterCard / VISA / Eftpos ☒ Cash ☒ Cheque

CHANGING / CANCELLING YOUR APPOINTMENT:

If for any reason you need to change the dental appointment you had scheduled, we would require a minimum of **<u>24 hours notice</u>** during working hours Monday to Friday. Late changes & failed appointments will incur a **<u>$ 120 fee</u>** to cover costs.
I have read the above terms and conditions and accept the same. I certify that the medical and other details provided by me above are correct to the best of my knowledge. I will advise you of any subsequent changes to my health and contact details. I confirm I may be contacted on email.

If the patient is a minor – the parent / caregiver / authorized person responsible for the minor and the account payable must sign.

SIGNED:____ **DATE:** ___________________________

NAME (of the authorized person):______________________**ADDRESS:**___________________________

Caring 4 Smiles welcomes you to a long term relationship in TOTAL ORAL CARE. IF YOU ARE DELIGHTED WITH OUR SERVICE, TELL YOUR FRIENDS, BUT IF WE CAN IMPROVE, PLEASE TELL US …………. We appreciate the feedback ……….. Dr Loy & the C4S Team.