Incredible Smiles

New Patient Form

P: 1800 ISMILES W: www.incrediblesmiles.com.au

About You

Title (Mr, Mrs ect.)

First name

Surname

Preferred name

Gender

Date of birth / /

Parent/Guardian's name (if under 18)

Home address

Phone Number (M)

(H)

(W)

Email Address

Preferred contact ☐ Phone ☐ Text ☐ Email

Occupation

Health fund

Member number

IRN (number next to your name)

Medicare number

Reference & Exp

GP/ Medical Clinic

Phone number

Person responsible for the account (if not you)

Emergency Contact

Full name

Relationship to you

Phone number

How did you find out about us?

☐ Google/Reviews ☐ Facebook

☐ Local/Drive by ☐ SADS

☐ Staff ☐ Health Fund

☐ Family/Friend Other?

If Friend or Family what is their name?

Consent to Treatment

I have answered all questions honestly and to the best of my knowledge. If further information is needed, you have my permission to ask the prospective healthcare provider or agency, who may release such information to you. I will notify the Dentist of any changes in my health or medication.

I authorise the Dentist/ designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.
Upon such diagnosis, I authorise the Dentist to perform all recommended treatments mutually agreed upon by me and to employ such assistance as required to provide proper care.

I authorise the Dentist and staff to perform and administer treatment, medication, and therapy that may be indicated. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

Payment T&C's

I understand that payment is due in full and payable at the time of treatment unless prior financial or other approved arrangements have been made. In the event the payments are not received by the agreed-upon dates, I understand that charges may be added to my account. I agree to be responsible for the payment of all services.

I understand that the practice requires at least 24hrs notice to cancel appointments or cancellation fees may apply.

Signature

Date / /

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Dental History

Why have you come to the dentist today?

Is there anything you would like to change about your smile? eg: colour, straighter, missing teeth?

Are you interested in any specific treatments?

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Does your jaw click or hurt? ☐ Yes ☐ No

Do you gums ever bleed when you brush? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Do you wear a night guard? ☐ Yes ☐ No

Have you ever had gum disease? ☐ Yes ☐ No

Have you ever had your bite adjusted? ☐ Yes ☐ No

Does food ever get caught between your teeth? ☐ Yes ☐ No

Do you have difficulty opening or closing your mouth? ☐ Yes ☐ No

Do you think you have occasional bad breath? ☐ Yes ☐ No

Do you feel you grind your teeth? ☐ Yes ☐ No

Do you experience sensitivity to hot/cold? ☐ Yes ☐ No

Do you bite your lips or cheeks often? ☐ Yes ☐ No

Does floss ever tear between your teeth? ☐ Yes ☐ No

Do you smoke or vape? ☐ Yes ☐ No

Do your teeth hurt if you bite hard? ☐ Yes ☐ No

Any pain in joint, ear or side of the face? ☐ Yes ☐ No

Your Health

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Weeks:

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following?

- ☐ Diabetes
- ☐ Asthma
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Latex sensitivity
- ☐ Rheumatic Fever
- ☐ HIV/Aids
- ☐ Kidney Problems
- ☐ Liver disease
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Tumours
- ☐ Tuberculosis (TB)
- ☐ Blood Transfusions
- ☐ Excessive Bleeding
- ☐ Haemophillia
- ☐ Excessive Bruising
- ☐ Epilepsy/ Seizures
- ☐ Anaemia
- ☐ Blood Disorders
- ☐ Psychiatric care
- ☐ Artificial joint/Valve
- ☐ Pacemaker or Surgery
- ☐ Heart Related issues
- ☐ Hepatitis A, B or C (Please specify)
  - ☐ A ☐ B ☐ C

or other (please list)

Do you have an allergies to any medications or drugs? Please specify:

☐ Yes ☐ No

Are you taking any medications?