YourSmileDental

PATIENT INFORMATION FORM

At Your Smile Dental we strive to provide you with the best possible care. To do this we need to collect personal information from you that includes contact details pertaining to your general health, both past and present. Without this information it is difficult for your dentist, therapist or hygienist to plan your care properly.

Please be assured that this information is maintained in accordance with the Northern Territory and Federal Privacy Legislation. If you would like any further information about how we use and protect your personal information, please ask one of our staff for a copy of Our Privacy Policy.

Title: **Given Name:**	**Surname:**
Preferred Name:	**D.O.B:**
Address:	
Suburb:	**Postcode:**
Home Phone:	**Work Phone:**
Mobile:	**Email Address:**
Do you have a private health fund? ❑ Smile Fund Member ❑ Other health fund (please specify): _____	
Occupation:	**Employer name:**
IN CASE OF EMERGENCY, WHO CAN WE CONTACT? **Name:** _____ **Relationship:**	**Phone Number/s:**
At Your Smile Dental, we remind our patients of their appointments. Please indicate your preferred means of contact. ❑ Home Phone ❑ Work Phone ❑ Mobile ❑ SMS Text ❑ Email	
Would you like to be kept informed via email with updates on what is new in the practice, services and new dental techniques that may affect your next visit? ❑ Yes ❑ No	
All accounts are to be settled at the end of each appointment. If a carer / guardian / parent is responsible for settling the account, please give details: **Name:**	**Relationship:**
Address (if different from above):	
Suburb:	**Postcode:**
Home Phone:	**Work Phone:**
Mobile:	

YourSmileDental

How did you find out about us?

❑ Practice Website ❑ Yellow Pages ❑ Sighted company vehicle ❑ Flyers

❑ Local Directories ❑ Location ❑ Internet search ❑ TV/Radio

❑ Facebook (where?): _____

❑ Word of mouth: Friend / Family (who): _____

❑ Other (please specify): _____

PATIENT INFORMATION FORM (continued)

How long is it since your last dental examination?

❑ 6 months ❑ 1 year ❑ 2 years ❑ 3 years ❑ longer

Please tick any dental concerns you have.

❑ Toothache ❑ Unsatisfactory denture ❑ Bad breath

❑ Sensitive teeth ❑ Rapidly decaying teeth ❑ Loose teeth

❑ Bleeding gums ❑ Pain in face or jaw joints ❑ Worn teeth

❑ Grinding / clenching teeth ❑ Sounds from joint ❑ Dry mouth

❑ Bad appearance of teeth ❑ Discoloured teeth ❑ Missing teeth

How do you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you smoke? ❑ Yes ❑ No

Who is your general practitioner? Name: _____ Phone: _____

Have you had, or are you suffering any of the below?

❑ Heart Condition ❑ HIV infection ❑ High Blood Pressure

❑ Rheumatic fever ❑ Excessive bleeding ❑ Diabetes

❑ Artificial joint ❑ Osteoporosis ❑ Stroke

❑ Hepatitis ❑ Thyroid problems ❑ Asthma

❑ Infectious diseases* ❑ Cancer ❑ Epilepsy

*eg/ CJD, TB, Staph, etc ❑ Radiation or Chemotherapy ❑ Sleep Apnoea

If yes to any of the above, please specify details: _____

Ladies, are you currently pregnant or breastfeeding? If so, please detail:

_____

Are you taking any of these medications?

❑ Warfarin (Coomadin / Marevan)

❑ Aspirin (Astrix / Cartia)

❑ Plavix (Iscover)

Are you taking any biphosphanate medications, or medications for osteoporosis, multiple myeloma, metastatic cancer or pagets disease? ❑ Yes ❑ No

(If yes, please specify): _____

What medications, including natural remedies are you taking?

(Please specify): _____

Are you allergic to anything? eg/ local anaesthetic, latex, penicillin, peanut etc

(Please specify): _____

Is there anything else about your health you believe we should know?

(Please specify): _____

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PATIENT INFORMATION FORM (continued)

Terms of Acceptance

- All dental treatment is carried out using up to date techniques, equipment and materials. All equipment is either disposable or sterilised using an autoclave which is validated daily for optimal efficiency.
- It is the policy of this practice to take diagnostic radiographs (x-rays) at the first examination and specific radiographs as required before certain procedures.
- A current periapical radiograph (x-ray) will be taken prior to any extraction. This is for your protection as well as ours.
- Any treatment required will be provided with the patient's informed consent after all risks associated with the treatment are outlined.
- All information on this form is considered confidential and is necessary to ensure that the best possible treatment can be provided.
- Each appointment made is a contract between Your Smile Dental and the patient. All appointments cancelled with less than 24 hours' notice will incur a minimum $150 cancellation fee.
- An estimate of fees for treatment should be outlined prior to treatment being provided. If you are not sure of estimated fees, you need to let us know.
- All fees incurred per appointment must be settled at the completion of that appointment.
- Dishonoured cheques will incur a $48 dishonour fee.
- Should any account for any reason become outstanding, then the patient or person responsible for the accounts will be responsible for all debt collection charges incurred.

I have accurately completed this pre-clinical questionnaire to the best of my knowledge and agree to the terms of acceptance. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatment.

Patient signature: _____ (parent or guardian to sign if patient is a minor)

I consent to Your Smile Dental taking a current photograph of myself to hold on record as part of my comprehensive patient file, this will not be used for any marketing purposes or disclosed to any third parties.

Initial: _____ Date: _____

OFFICE USE ONLY

Checked by*: _____ Print Name: _____ Date: _____
(*staff member signature)