YourSmileDental

PATIENT INFORMATION FORM

At **YourSmileDental** we strive to provide you with the best possible dental care. To do this, we need to collect personal information from you that includes contact details and details pertaining to your general health, both past and present. Without this information, it is difficult for your dentist, oral health 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: **First Name:** **Surname:**

Preferred Name: **Date of Birth:**

Home Address: **Suburb:** **Postcode:**

Postal Address: **Suburb:** **Postcode:**
Same as home address ❑

Home Phone: **Work Phone:**

Mobile: **Email Address:**

Are you with a Private health fund or Dental Plan? ❑ No Health Fund

❑ Private Health Fund: ______________________ Health Fund No: _____________________ Sequence No: _______

____

❑ Smile.com.au Member Smile Membership No: ______________________ Expiry Date: __________________

❑ Medicare No: ____________________________ Sequence No: _______

Occupation: **Employer name:**

IN CASE OF EMERGENCY, WHO CAN WE CONTACT? **Name:** ____
Relationship: **Phone Number:**

At Your Smile Dental, we remind our patients of their appointments. Please indicate your preferred means of contact.

❑ Mobile ❑ SMS Text ❑ Email ❑ Home Phone ❑ Work Phone

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

I understand that all accounts are to be settled at the end of each appointment ❑

Please note that it is your responsibility to contact your Private Health Fund to confirm your level of dental cover prior to your appointment.

If you are the carer / guardian / parent of the patient named above and are responsible for settling the account, please give your details:
Name: **Relationship to patient:**

Address (if different from above):

Suburb: **Postcode:**

Home Phone: Work Phone**:** **Mobile:**

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PATIENT INFORMATION FORM (continued)

How did you find out about us?

❑ Practice Website ❑ TV/ Radio ❑ Location ❑ Internet search ❑ Local Directories | Yellow Pages
❑ Social Media ❑ Private Health Fund ❑ Other (please specify): ____
❑ Word of mouth: Friend / Family (who do we have to thank?): ____

How long ago was your last dental visit?

❑ 6mths - 1 year ❑ >1yr ❑ 2-3 yrs ❑ 3-4 yrs ❑> 4yrs **Please specify years:** __________

Please tick any dental concerns you have.

❑ Toothache ❑ Grinding/Clenching Teeth ❑ Discoloured Teeth
❑ Sensitive Teeth ❑ Bad Appearance of Teeth ❑ Worn Teeth
❑ Bleeding Gums ❑ Pain in Face or Jaw ❑ Missing Teeth

Reason for today's visit: ____

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

Do you smoke? ❑ No ❑ Yes - How many cigarettes per day? ____________

General practitioner details:
Name: Dr Practice: State:

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

❑ Heart Condition - Please given details: ____________________________ ❑ HIV infection
❑ High Blood Pressure ❑ Rheumatic fever with heart valve defects ❑ Excessive bleeding
❑ Low Blood Pressure ❑ Diabetes ❑ Artificial joint ❑ Osteoporosis
❑ Stroke ❑ Hepatitis ❑ Thyroid problems ❑ Asthma
❑ Epilepsy ❑ Infectious diseases eg. CJD, TB, Staph. Please specify: ___________
❑ Cancer - Please give details: __________________________________
❑ Radiation or Chemotherapy ❑ Psychological issues - Please give details: ____________

Have you had recent surgery? Please provide details: _______________________________________

Please detail any other relevant information: ____

Ladies, are you currently pregnant or breastfeeding? If so, please detail:
❑ **Pregnant, no. of weeks:** ___________ ❑ **Breast feeding**

Are you taking any of these medications?

❑ Warfarin ❑ Aspirin ❑ Other blood thinner. Please specify: _______________

Are you taking any bisphosphonate medications, or medications for osteoporosis, multiple myeloma, metastatic cancer or Paget's disease? ❑ Yes, please specify ____ ❑ No

What medications, including natural remedies are you taking?

(Please specify): ____

Are you allergic to anything? Eg. local anaesthetic, latex, penicillin, peanut etc

(Please specify): ____

Have you previously received any of the following treatments?

Botox / Dermal Filler Injections / Dysport, Facial Treatment – e.g. laser, micro-dermabrasion ❑ Yes ❑ No

(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 sterilised (using an autoclave which is validated daily for optimal efficiency), disposable or disinfected prior to use.
- 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 (such as an extraction or root canal treatment).
- Pictures of your teeth and mouth are taken routinely for your records and to aid in diagnosis (intraoral).
- 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 **YourSmileDental** and the patient or responsible guardian.
- Each appointment made must be confirmed the business day prior, or the appointment will be released and a new appointment will need to be made.
- Any *Late Notice Cancellations* (less than 24 hours' notice) or *Fail to Attend* appointments will incur a minimum fee of **$150**.

- A Treatment Plan for future treatment with fees will be outlined by the dentist, oral health therapist or hygienist prior to treatment being provided.
- **All fees incurred per appointment must be settled at the completion of that appointment.**
- It is your responsibility to check with your Private Health Fund provider in relation to you benefits (entitlements) prior to all future appointments.
- 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.
- **Early Release of Superannuation for Treatment**: **YourSmileDental** does not provide this service.

I have accurately completed this pre-clinical questionnaire to the best of my knowledge and fully understand & 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)**

Date: __________________________ **If guardian, relationship to patient:** ________________________

Do you consent to YourSmileDental taking a photograph of you (or your child/dependant) for your patient file? Photos taken are ***Strictly Confidential*** and will not be used for any marketing purposes or disclosed to any third parties.

❑ **Yes** ❑ **No**

OFFICE USE ONLY

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