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, 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 ❑ Company Vehicle ❑ Flyers
❑ Location ❑ Internet search ❑ Local Directories | Yellow Pages
❑ Facebook ❑ Private Health Fund ❑ Bus Advertisement ❑ Cinema
❑ Other (please specify): _____Word of mouth: Friend / Family (who): _____

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:

Practice: Phone number (if known):

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): _____

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 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 Your Smile Dental and the patient.
- 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**.

- 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.**
- 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)

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)