plentysmiles

Quality dentistry for everyone

It is important the details about your medical history as these could affect the success of your dental treatment. The information you provide is confidential and will be handled in accordance with the Australian Dental Association privacy policy.

Given Names: Family Name:

Title: Mr Mrs Miss Master Ms Dr Date of Birth:

Address: Suburb:

Hm. Phone: Mobile: Work Ph.

Email: Occupation:

How did you find us: family, friends, Google, referred by, other? :

In case of emergency: Name: Phone:

Your GP: Name: Phone:

Private Health Fund with Dental Cover: Yes / No If so, which fund?

What would be a good outcome from today's visit?

Please tick all applicable health conditions that apply to you:

Heart Murmur
Anaemia, Leukaemia
Steroids Therapy
Reaction To Anaesthetics
Drug Addiction
Drink alcohol
Bone Disease
Other Lunge disease
Diabetes
Artificial HIP/KNEE/ANKLE
Nervous Condition
Bone Problems
Tuberculosis
Hepatitis A B C
Osteoarthritis
High or Low Blood Pressure
Pace Maker
Heart Condition
Thyroid Problems
Asthma
HIV/AIDS Related Condition
Bronchitis
Rheumatic Fever
Excessive Bleeding
Epilepsy
Osteoporosis
Stroke
Kidney Issues
Emphysema
Cancer

Do you have or have you had any disease, condition or problem not listed?

Please list any known allergies (latex, penicillin, etc.)

Are you being treated by a doctor at present?

Are you taking any medicines and what are they?

Do you Smoke? How many per day?

Are you Pregnant? How many weeks?

Please tick all applicable health conditions that apply to you:

Alendro	*Bonefos*	*Denosumab*	*Fosomax*	*Skelid*
Aredia	*Bonevia*	*Dridronel*	*Pamisol*	*Zometa*
Actonel				

Please tick all applicable health conditions that apply to you:

I Snore

I suffer from regular headaches

My jaw 'clicks' or hurt

I bite my lips or cheeks often

I wear a dental night guard

My bite has been adjusted

I have had orthodontic (braces) treatment

My teeth hurt when I bite hard

I have bad breath

My gums bleed when I clean my teeth

I have had specialist periodontal (gum) treatment

I have sensitive teeth e.g. sensitive to cold and hot

How long has it been since your last dental appointment?

How often do you have dental examinations?

When were your last dental x-rays taken?

Is there any other medical information you would like us to know?

Would you be interested in knowing about Whitening, Smile Enhancing or Smile Makeover?

Consent for Treatment

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

We accept American Express or Direct Bank Deposit as forms of payment as well as MasterCard and Visa cards, EFTPOS, Cash & Cheques. Overdue accounts will be sent to debt collector which will incur extra processing and administrations fees.

Please try to keep your appointment .We have set aside the time exclusively for you. If you are unable to keep the appointment please give us 24 hours' notice or a cancellation charge of $50 may apply.

Thank you for your assistance.

Patient /Guardian/ Carer Signature

Date