SmileDynamics

A Warm Welcome to Our Practice!

Please fill in the following completely.
It contains information that will assist us in providing the very best dental treatment for you.
We respect your privacy and all information will be handled with complete confidentiality.

SURNAME Mr. Mrs. Ms. : _____

FIRST NAME : _____

DATE OF BIRTH : ____ /_____ / _____

OCCUPATION : _____

HOME ADDRESS : _____

_____

BUSINESS ADDRESS : _____

_____

TELEPHONE HOME : _____

TELEPHONE WORK : _____

MOBILE PHONE : _____

FAX NUMBER : _____ _____

EMAIL ADDRESS : _____

YOUR DOCTOR : _____ PHONE : _____

ARE YOU SEEING ANY OTHER SPECIALISTS? (EG PHYSIOTHERAPIST, OSTEOPATH, ENT) : _____

_____

PHONE : _____

NAME OF YOUR HEALTH FUND FOR DENTAL INSURANCE : _____

_____

WHO CAN WE THANK FOR REFERRING YOU TO US? : _____

_____

MEDICAL HISTORY

1. Are you taking and drugs or medicines? : _____

_____

2. Are you allergic to anything, eg antibiotics, medicines etc.? : _____
3. If pregnant, please state how many months? : _____
4. Have you ever had prolonged bleeding or any problems with tooth extractions? : _____

_____

5. Do you smoke? Yes / No. If yes, how many a day? : _____

Please place a tick in the space below if you have had any of the following:

1. Rheumatic fever or valvular diseases of heart	☐	Please give details : _____
2. Open heart surgery &/or prosthetic heart valve	☐	_____
3. Infectious endocarditis (or bacterial endocarditis)	☐	_____
4. Heart disease, heart surgery or bypass surgery	☐	_____
5. High or low blood pressure	☐	_____
6. Stroke (CVA)	☐	_____
7. Asthma	☐	_____
8. Any other allergic disorder	☐	_____
9. Sinusitis or hayfever	☐	_____
10. Progressive neurological illness	☐	_____
11. Hepatitis (A,B, C or any viral hepatitis)	☐	_____
12.HIV or AIDS	☐	_____
13. Thyroid disease	☐	_____
14. Chemotherapy or radiation to head or neck	☐	_____
15. Arthritis	☐	_____
16. Diabetes	☐	_____
17. Fits or epilepsy	☐	_____
18. Kidney disease	☐	_____
19. Muscle diseases or wasting disease	☐	_____
20. Depression or other psychic condition	☐	_____
21. Osteoporosis	☐	_____
22. Joint replacement surgery? (e.g) Hip, shoulder, knee etc	☐	_____

DENTAL

1. What is the purpose of your visit today? : _____
2. Are you completely satisfied with the appearance of your teeth and smile? : _____
3. What would you like to change about your teeth or smile? : _____
4. Do you grind or clench your teeth? : _____
5. Do you suffer from headaches? : _____
6. Do your gums bleed when you brush or floss? : _____
7. How long since your last dental appointment? : _____

Signature : _____ Name : _____

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