SENSATIONAL SMILES
DENTAL

To help us provide you with the best care possible please fill out the following questionnaire. All information is kept confidential and is used strictly for your treatment needs.

Please fill in this form completely.

Personal Details

Title: _____ Family Name: _____ Given Name(s): _____

Preferred Name: _____ DOB: _____ Occupation: _____

Address: _____ Postcode: _____

Phone (Home): _____ Phone (Mobile): _____

Email: _____

Health Fund: _____ Number on Card **e.g. 01**: _____

Name of your GP: _____ Contact Number: _____

How did you hear about us?

Existing Patient (if so, who?): _____

Other (Please specify): _____

Medical History

Medical Conditions: Do you have or have you ever had any of the following?
Please tick the appropriate boxes below:

Heart Attack	Prolonged Bleeding	Cancer
Heart Murmur	Blood Transfusion	Rheumatic Fever
Cardiac Surgery	Anaemia	Liver Disease
Pacemaker	High Blood Pressure	Kidney Disease
Artificial Valve	Low Blood Pressure	Nervous Disorders
Chest Pain / Angina	Diabetes	Epilepsy
Lung Disease	Arthritis	Fainting Tendency
Asthma	Prosthetic Joint	Stroke
Shortness of Breath	Placement	Thyroid Disease
Hay Fever	Osteoporosis	Tuberculosis
Sinus Trouble	Radiation Treatment	Hepatitis/HIV

Do you have any other medical conditions we should be informed about?

_____

Do you have any Allergies: *(e.g. Penicillin, latex, local anaesthetics?)*

_____

Medications: *Please list all medications; prescription, herbal, alternative*

_____

Have you ever taken Bisphophonate medications? *(Didronel, Fosamax, Aredia, Pamisol, Zometa, Bonefos, Skelid, or Bonviva)*

_____

Have you been hospitalised recently? If yes, why and when?

_____

(Female Patients) Are you, or could you be pregnant or breast feeding?

_____

Do you smoke? If yes, how many cigarettes per day?

_____

Dental History

What is the reason for your visit to us today?

_____

When was your last visit to the dentist?

_____

Do you suffer from headaches/neck pain/clicking jaw/snoring or sleep apnoea? Please circle.

_____

Have you ever had a difficult tooth extraction?

_____

Have you suffered anxiety/stress when visiting your dentist in the past? If so please explain?

_____

What would make you more comfortable during your treatment with us?

_____

Do you consent to photos taken by the dentist being used for training/teaching purposes?

☐ Yes ☐ No

Are there any other concerns or questions which you would like to be addressed by the dentist or Sensational Smiles Dental Clinic staff?

_____

I consent to the Dental Procedures and anaesthetics that are necessary for my treatment. I also agree to assume all financial responsibility for treatment rendered.

SIGNATURE: _____ DATE: _____