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 child's treatment needs.

Please fill in this form completely.

Personal Details

Family Name: ____ Given Name(s): ________________

DOB: ___________________________ Parent's Name: ____________________________________

Address:____ Postcode: _________________

Phone (Home): ____________________________ Parent's Mobile: __________________________

Parent's 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 Placement	Stroke
Shortness of Breath		Thyroid Disease
Hay Fever	Osteoporosis	Tuberculosis
Sinus Trouble	Radiation Treatment	Hepatitis/HIV

Does your child have any other medical conditions we should be informed about?
____

Does your child have any Allergies: *(e.g. Penicillin, latex, local anaesthetics?)*
____

Medications: *Is your child on any medications; prescription, herbal, alternative*

____

Dental History

What is the reason for your visit to us today?

____

When was your child's last visit to the dentist?

____

Does your child suffer from headaches/neck pain/clicking jaw/snoring or sleep apnoea? Please circle.

____

Has your child ever had a difficult tooth extraction?

____

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

____

What would make your child more comfortable during their 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 child's treatment. I also agree to assume all financial responsibility for treatment rendered.

SIGNATURE: ____ DATE:____________________

Name: ____

Relationship to child: ________________________________