Integrated Smiles
General Dentistry Implants & Orthodontics

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We are pleased to welcome you to our surgery. The following information is necessary to enable us to provide you with the best dental care. All information is strictly confidential.

Your Details

Title:_____Surname:_____ Given Names:_____

Gender:_____Date of Birth:_____Occupation:_____

Residential Address:_____

Postal Address:_____

(Please circle preferred contact) Email address:_____

Phone Home:_____Work:_____Mobile:_____

Your Emergency Contact/Family Details

Name:_____ Relationship:_____Phone:_____

Your Medical History

Name of your GP:_____GP Contact Details:_____

Please Circle if you have had or are suffering from any of the following?	**Yes (Y) or No (N)**	
Cardiovascular problem (shortness of breath, heart attack, stroke, angina)	Y	N
Rheumatic Fever, Heart Murmur, Inborn Heart Defect.	Y	N
Artificial Joint, Heart Valve or Prosthetic Implant.	Y	N

High Blood Pressure	Y	N	Low Blood Pressure	Y	N
Diabetes (circle Type I or II)	Y	N	Asthma/Breathing Problem	Y	N
Stomach/Bowel Problems (eg Ulcer)	Y	N	Tuberculosis	Y	N
Kidney Disease	Y	N	Thyroid or Endocrine	Y	N
Excessive Bleeding or Blood Disorder	Y	N	Epilepsy or Seizures	Y	N
Hepatitis	Y	N	AIDS/HIV	Y	N
Cancer or Tumor	Y	N	Radiation Treatment	Y	N
Bone Disorders or Disease	Y	N	Chemotherapy	Y	N
Rheumatoid or Arthritic Condition	Y	N	Acid Reflux	Y	N
Anaemia or Fainting (circle either)	Y	N	Creutzfeldt-Jacob Disease	Y	N
Special Care or Learning Disability	Y	N	Mental Condition	Y	N
Are you pregnant	Y	N	Anticipating Pregnancy	Y	N
Smoker	Y	N			

Please list details if you have ticked yes to any of the above:_____

_____

_____

Please list any allergies, including medicines and products (eg, Penicillin, Latex):_____

_____

Please list all medications that you are taking:_____

_____

_____

Your referral details: How did you hear about our office? **Please Tick**

☐ Facebook ☐ Radio ☐ Location ☐ Google/Website

☐ Friend ☐Family ☐ Work Colleague ☐ Yellow Pages ☐ Other

Thank you for noting down name of referee so that we can thank them_____

Account Details:

Please note that we ask for payment on the day of treatment. Eftpos and Hicaps are available.

Who is responsible for settling the account?_____

Name of health insurance fund if applicable?_____

How we can help you with your oral health concerns: Your Dental History

What have you come to see us for today?_____

How would you like us to help you?_____

Does dental treatment make you nervous?_____

Note down any problems that you have had with dental treatment in the past?_____

_____

Is there anything that you would like to discuss with the dentist in private?_____

Do you have concerns with any of the following? Please CIRCLE Yes (Y) or No (N)

Bleeding Gums or Bad Breath	Y	N	Trouble with Brushing or Flossing	Y	N
Discoloured Teeth or Fillings	Y	N	Chipped or Broken Teeth	Y	N
Worn Down Teeth	Y	N	Tooth Grinding or Clenching	Y	N
Jaw Clicking or Hurting	Y	N	Snoring or Sleep Apnoea	Y	N
Teeth Sensitive to hot/cold	Y	N	Loose Teeth	Y	N
Missing Teeth/Gaps	Y	N	Ill-fitting Dentures	Y	N
Aesthetics or Appearance of Teeth	Y	N	Difficulty in Chewing/Jaw Opening	Y	N

Orthodontic treatment *We now offer a comprehensive orthodontic treatment range. If you are interested in orthodontic treatment please tick boxes below to the following:*

Have you ever had a prior orthodontic examination or treatment? Y N

Have you ever had or are suffering from any of the following?

Spaced Teeth or Gaps	Y	N	Crooked Teeth	Y	N
Protruding Teeth	Y	N	Tongue Thrusting	Y	N
Thumb or Finger Sucking Habit	Y	N	Until what age?_____		
History of Speech Problems	Y	N	Mouth Breathing	Y	N
Treatment for TMJ (jaw joint)	Y	N	Pain in Head or Neck Region	Y	N

Thank you for your assistance in completing this form as fully as possible.

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

So that we can serve you better, do you consent to quarterly email newsletters and occasional offers and updates? Y N

Date:_____ **Signed:_____**