THE SMILE PLACE
Mt Eliza

Welcome! We appreciate the confidence you have placed in us. To assist us in providing the best possible care, please complete the important health information on this form. We assure you that the information you give will remain **STRICTLY CONFIDENTIAL.** **Please feel welcome to ask for assistance.**

Name:.....
Title First Names Last Name

I like to be called: .....Date of Birth: ...../...../..... ❒ Male ❒ Female

Address:.....

Postal (if different):.....

H:.....W:.....M:.....**Best: ❒H ❒W ❒M**

Email Address: .....

Are you happy to receive information on special offers via email (not more than 2 per month)? ❒ Yes ❒ No

Health Fund for Dental ❒ Yes ❒ No Which fund?.....

Name of your Medical Doctor: ..... Phone:.....

Would you like reminders for your appointments? ❒ SMS ❒ Email ❒ Telephone

Have you **EVER** had any of the following? Tick those that apply ☑

❒ **Heart Murmur**	❒ **Rheumatic Fever**	❒ **Artificial Joints**
❒ **Asthma**	❒ **Hepatitis A, B, C**	❒**HIV/AIDS**

Do you now (or have you recently) suffered from any of the following

❒ Excessive Bleeding	❒ Heart Pacemaker	❒ Fainting/Dizziness
❒ Respiratory Disease	❒ Healing Complications	❒ Diabetes
❒ Heart Surgery/Disease	❒ Chest Pain	❒ Blood disease
❒ Cancer or Tumour	❒ Radiation Treatment	❒Chemotherapy
❒ Low Blood Pressure	❒ High Blood Pressure	❒ Stroke
❒ Liver Disease	❒ Kidney Disease	❒ Epilepsy
❒ Thyroid problems	❒ Sinus Trouble	❒ Arthritis
❒ Stomach Problems	❒ Bowel Problems	❒ Depression
❒ Nervousness /Anxiety	❒ Psychological Disorders	❒ Other

Details:.....

.....

List **any** medicines you take .....

List any ALLERGIES (eg. Medicines, Latex, other) :.....

Next of Kin (in case of Emergency):

Full Name: ..... Phone: .....
Title First Name Last Name

Are you Pregnant? ❒ Yes ❒ No Breastfeeding? ❒ Yes ❒ No

Do you

1. Smoke? ❒ Yes ❒ No
2. Snore? ❒ Yes ❒No
3. Play contact sports? (eg Football, Netball) ❒ Yes ❒No

Tick ☑ if you are experiencing any of these problems

❒ Sensitivity to cold or hot
❒ Food trapped between teeth
❒ Bad taste or bad breath
❒ Mouth ulcers
❒ Painful teeth when biting
❒ Bleeding gums
❒ Stained teeth or fillings
❒ Jaw clenching or grinding
❒ Roughness of teeth
❒ Head/Neck ache
❒ Clicking of jaw joints
❒ Dry mouth

Tick ☑ if you are **un**happy with the following?

❒ Appearance of your teeth
❒ Your smile
❒ Your ability to eat
❒ The colour of your teeth
❒ Shape of teeth
❒ Fillings
❒ Crowns
❒ Bridge
❒ Dentures
❒ Cleaning technique

Whom may we thank for referring you? .....

How did you find out about us? .....

If online, please complete additional information (attached) *Thank you!*

Consent for Services

To the best of my knowledge, the preceding answers and all information provided are true and correct. Should I have any change in my health status or personal details, I will inform the doctor at my next appointment, without fail. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other practitioners to aid them in my treatment and consent to this.
I understand that dental treatment must be paid in full at the time of treatment. I acknowledge that if an account is overdue The Smile Place Mt Eliza reserve the right to refer the account to a third party. I agree to meet all reasonable costs incurred by The Smile Place Mt Eliza in employing the said third party, to collect the overdue account.

Signature: ..... Date: ..... / ..... /.....

Relationship to child if Parent or Guardian.....
(If the patient is under 18 years of age, Parent or Guardian must complete and sign form)