

Patient Name: _____

Smile Artistry™

DENTAL AND MEDICAL EVALUATION FORMS



Strong Teeth, Healthy Gums, Beautiful Smiles!

Please complete these forms to assist us to evaluate your dental treatment needs.

PRIVATE AND CONFIDENTIAL

All information in this document will remain private and confidential, and is held in accordance with Smile Artistry's Privacy Policy, viewable at <http://www.smileartistry.com.au/privacy-policy>

Phone (07) 3870 3344

Email info@smileartistry.com.au

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PO Box 714, Toowong QLD 4066

CONTACT DETAILS FORM

Smile Artistry™

We welcome you to Smile Artistry! We ask you to provide the following information to help us provide you with personalised dental care.

TITLE: _____ FIRST NAMES: _____ SURNAME: _____

DATE OF BIRTH: ____/____/____

Name of person responsible for payment of fees: _____

HOME ADDRESS: _____

POSTCODE: _____

POSTAL ADDRESS: _____

PHONE NUMBERS: Home: _____ Work: _____ Mobile: _____

(Please circle preferred contact number)

EMAIL ADDRESS: _____

PLACE OF EMPLOYMENT: _____

NEXT OF KIN: Name: _____ Phone: _____

Address: _____

Please let us know how you were referred to us:

- 1. Friend, Family or Work Colleague *Please give name:* _____
- 2. Magazine *Please indicate magazine and month:* _____
- 3. Yellow Pages
- 4. Internet *Please indicate what words you were searching for:* _____
- 5. Yellow Pages Online
- 6. Billboards, Signs
- 7. Other Sources *Please provide further information:* _____



MEDICAL HISTORY FORM

Smile Artistry™

NAME: _____

Date of Birth: _____

Please let us know of your health status by ticking the appropriate boxes and providing further details as necessary,

Heart Conditions/Problems Yes No

Bypass Surgery or Pacemaker Yes No

History of Rheumatic Fever Yes No

History of Heart Murmur Yes No

Prosthetic Joint Replacements Yes No

Do you usually require Antibiotic Cover prior to Dental Treatment? Yes No

Blood Disorders, Anaemia Yes No

Tendency to Bleed Yes No

Blood Pressure Concerns Yes No

Tumour History Yes No

Diabetes Yes No

Liver or Kidney Problems Yes No

Asthma Yes No

Arthritis Yes No

Epilepsy Yes No

Ulcers (Stomach Ulcers TC) Yes No

Sinus Problems Yes No

Antidepressant Medication Yes No

HIV+ Yes No

AIDS Yes No

Hepatitis A B C

Have you ever had Chemotherapy treatment? Yes No

Have you taken any Bisphosphonate medication in the last 10 years? Yes No

(This includes Fosamax, Actonel for the treatment of Osteoporosis)

FEMALES: Are you Pregnant? Yes No

Have you ever had an allergic reaction to any treatment or medications below?

Anaesthetics Yes No

Penicillin Yes No

Other Medications, Please give details: _____

Please let us know your current General MEDICAL Practitioner: _____

Do you have any other health issues we should be aware of? _____

Please list all medications you are currently taking: _____

Should your Medical Status change or you begin taking new medications, please bring this to the attention of your Dentist before Dental Treatment.

Please Sign: _____

Today's Date: _____



ABOUT THE FUNCTION OF YOUR MOUTH

- Have you had trouble with previous dental experiences? Yes No
- Does your jaw click or hurt? Yes No
- Do you feel you grind or clench your teeth? Yes No
- Do you have difficulty chewing? Yes No
- Have your teeth worn down, discoloured, or are moving? Yes No
- Do you wear a protective night splint? Yes No

ABOUT THE APPEARANCE OF YOUR SMILE

- Do you like the arrangement of your teeth? Yes No
 - Do you like the shape of your teeth? Yes No
 - Do you like the colour/shade of your teeth? Yes No
 - Do you have spaces between your teeth? Yes No
 - Does their appearance concern you? Yes No
- How would you improve the appearance of your smile?
- Colour Length Shape Arrangement

Other comments: _____

ABOUT THE HEALTH OF YOUR MOUTH

- Do your gums look and feel healthy? Yes No
 - Do your gums bleed when you clean your teeth? Yes No
 - Do you suffer from bad breath? Yes No
 - Are you a smoker? Yes No
- How many times each day do you clean your teeth? _____
- How Many times each day do you floss your teeth? _____

To assist our Reception Staff prepare our Dentists for your appointment,

PREVIOUS DENTIST'S NAME: _____

PREVIOUS DENTAL X-RAYS: Less than a year More than a year

Have you had recent dental treatment? Please indicate which type of procedures: _____

PLEASE SIGN _____ **DATE:** ____ / ____ / ____

(Photos of teeth and smiles taken remain the property of Smile Artistry PL. Copies of these 'before' and 'after' photos may be used for patient resource material or for advertising purposes).

