Smile Artistry™ Dental Practice

Personalised Care in General, Implant and Cosmetic Dentistry

Please take some time to keep us up-to-date with your details and ensure we understand your current health,

First Name ____________________ Surname ____________________

Preferred Name ____________________ Date of Birth ____________________

Home Address: ____________________ Postcode ____________________

Phone Numbers, Home ____________________ Work: ____________ Mobile: ____________

Your email address is used for appointment reminders and communication regarding your dental care. For privacy reasons, we suggest providing a private email as information regarding specific treatments may be sent via email.

Email ____

Which is the best contact method to contact you? ☐ Home ☐ Work ☐ Mobile ☐ Email

If we need to contact you, what is the best time of the day to contact you between 8am and 6pm: ____________________

YOUR APPOINTMENT POLICY

The following is a statement of our Financial Policy which we require you to read, understand, and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF TREATMENT.
WE ACCEPT HICAPS, CASH, EFTPOS, ELECTRONIC BANK TRANSFERS (in advance) AND CREDIT CARDS.

DENTAL FEES

Our practice is committed to providing you with the best treatments and we charge what is usual and customary for the service. You will be informed of fees before your treatment begins. It is your responsibility to discuss any financial concerns you have before your treatment is commenced.

Smile Artistry will assist by processing your Private Health Fund Claim at the time of your Appointment, and the remainder of fees will become your full immediate responsibility. Payment by Cheque and Electronic Bank Transfer must be made three days in advance of the treatment.

CHANGING APPOINTMENTS

To ensure we run on-time for your appointments and the appointments of our other patients we require at least two business days notice to change your appointment times. If you are late to an appointment your appointment may be rescheduled and a fee charged. If you miss an appointment a fee will be charged. Please note, due to privacy laws, we are unable to change appointments via email.

TREATMENT CONDITIONS

To ensure the confidentiality of our patients and staff and to ensure your appointments are on-time, we do not allow photographic and video cameras to be used in our surgeries. **Mobile Phones are to be switched off in the surgeries.**

Thank-you for understanding the outlined policies above. Please let us know if you have any questions or concerns. I understand and agree to the policies stated.

Name of Patient (Please Print) ________________________________

Signature of Patient or Responsible Guardian ________________________

Date ____________________

Please turn over to Medical Update

MEDICAL HISTORY

Patient Name ______________________________ Nickname ____________ Age ______

Name of Physician/and their specialty ______________________________

Most recent physical examination ____________________ Purpose ____________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ____________
2. an allergic reaction to ____________
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ________)
   - latex
   - other ____________
3. heart problems, or cardiac stent within the last six months __
4. history of infective endocarditis ____________
5. artificial heart valve, repaired heart defect (PFO) ________
6. pacemaker or implantable defibrillator ________
7. orthopedic implant (joint replacement) ________
8. rheumatic or scarlet fever ____________
9. high or low blood pressure ____________
10. a stroke (taking blood thinners) ____________
11. anemia or other blood disorder ____________
12. prolonged bleeding due to a slight cut (INR > 3.5) ________
13. emphysema, shortness of breath, sarcoidosis ________
14. tuberculosis, measles, chicken pox ____________
15. asthma ____________
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____________
18. liver disease ____________
19. jaundice ____________
20. thyroid, parathyroid disease, or calcium deficiency ________
21. hormone deficiency ____________
22. high cholesterol or taking statin drugs ________
23. diabetes (HbA1c =______) ____________
24. stomach or duodenal ulcer ____________
25. digestive disorders (i.e. celiac disease, gastric reflux) ______
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __

YES NO

27. arthritis ____________
28. autoimmune disease ____________
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____________
30. contact lenses ____________
31. head or neck injuries ____________
32. epilepsy, convulsions (seizures) ____________
33. neurologic disorders (ADD/ADHD, prion disease) ______
34. viral infections and cold sores ____________
35. any lumps or swelling in the mouth ____________
36. hives, skin rash, hay fever ____________
37. STI / STD / HPV ____________
38. hepatitis (type ___) ____________
39. HIV / AIDS ____________
40. tumor, abnormal growth ____________
41. radiation therapy ____________
42. chemotherapy, immunosuppressive medication ______
43. emotional difficulties ____________
44. psychiatric treatment ____________
45. antidepressant medication ____________
46. alcohol / recreational drug use ____________

ARE YOU:

47. presently being treated for any other illness ________
48. aware of a change in your health in the last 24 hours
    (i.e. fever, chills, new cough, or diarrhea) ________
49. taking medication for weight management ________
50. taking dietary supplements ____________
51. often exhausted or fatigued ____________
52. experiencing frequent headaches ____________
53. a smoker, smoked previously or use smokeless tobacco _
54. considered a touchy / sensitive person ________
55. often unhappy or depressed ____________
56. taking birth control pills ____________
57. currently pregnant ____________
58. prostate disorders ____________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ____________

Doctor's Signature ______________________________ Date ____________

ASA ______ (1-6)

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