



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 | | YES NO |
|---|--|---------------|--|---|
| 1. hospitalization for illness or injury _____ | | | | 27. arthritis _____ |
| 2. an allergic reaction to _____
aspirin, ibuprofen, acetaminophen, codeine
penicillin
erythromycin
tetracycline
sulfa
local anesthetic
fluoride
metals (nickel, gold, silver, _____)
latex
other _____ | | | | 28. autoimmune disease _____
(i.e. rheumatoid arthritis, lupus, scleroderma) |
| 3. heart problems, or cardiac stent within the last six months _____ | | | | 29. glaucoma _____ |
| 4. history of infective endocarditis _____ | | | | 30. contact lenses _____ |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | | | | 31. head or neck injuries _____ |
| 6. pacemaker or implantable defibrillator _____ | | | | 32. epilepsy, convulsions (seizures) _____ |
| 7. orthopedic implant (joint replacement) _____ | | | | 33. neurologic disorders (ADD/ADHD, prion disease) _____ |
| 8. rheumatic or scarlet fever _____ | | | | 34. viral infections and cold sores _____ |
| 9. high or low blood pressure _____ | | | | 35. any lumps or swelling in the mouth _____ |
| 10. a stroke (taking blood thinners) _____ | | | | 36. hives, skin rash, hay fever _____ |
| 11. anemia or other blood disorder _____ | | | | 37. STI / STD / HPV _____ |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | | | | 38. hepatitis (type ____) _____ |
| 13. emphysema, shortness of breath, sarcoidosis _____ | | | | 39. HIV / AIDS _____ |
| 14. tuberculosis, measles, chicken pox _____ | | | | 40. tumor, abnormal growth _____ |
| 15. asthma _____ | | | | 41. radiation therapy _____ |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____ | | | | 42. chemotherapy, immunosuppressive medication _____ |
| 17. kidney disease _____ | | | | 43. emotional difficulties _____ |
| 18. liver disease _____ | | | | 44. psychiatric treatment _____ |
| 19. jaundice _____ | | | | 45. antidepressant medication _____ |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | | | | 46. alcohol / recreational drug use _____ |
| 21. hormone deficiency _____ | | | | ARE YOU: |
| 22. high cholesterol or taking statin drugs _____ | | | | 47. presently being treated for any other illness _____ |
| 23. diabetes (HbA1c = _____) _____ | | | | 48. aware of a change in your health in the last 24 hours
(i.e. fever, chills, new cough, or diarrhea) _____ |
| 24. stomach or duodenal ulcer _____ | | | | 49. taking medication for weight management _____ |
| 25. digestive disorders (i.e. celiac disease, gastric reflux) _____ | | | | 50. taking dietary supplements _____ |
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | | | | 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 _____