Beyond Smiles
DENTISTRY

Dear Patient,
We ask you to provide the following pre-treatment information. The information we collect enables us to provide you with better care. Your privacy is important to us, so all information provided will be kept strictly confidential.

YOUR DETAILS

Title : ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Others_____

Given Name : _____ Preferred Name : _____ Surname : _____

Date of Birth : _____ Postal Code : _____

Home Address : _____

Mobile Phone : _____ Home Phone : _____

Email : _____

BUSINESS CONTACT DETAILS

Your Occupation : _____ Work Phone : _____

Business Name : _____

Business Address : _____

Postal Code : _____

EMERGENCY CONTACT DETAILS

Name : _____ Contact No. : _____

Relationship to you : _____

DENTAL INFORMATION

What is the purpose of your visit today : _____

Have you had any problems with past dental treatment? ☐ Yes ☐ No

If yes, please explain : _____

Do you belong to a Health Fund? ☐ Yes ☐ No

If Yes, Which one? _____ Membership No. : _____ Ref No : _____

Are you a Veteran Affairs Card Holder? ☐ Yes ☐ No Card No. :_____

How did you hear about this practice? _____ To whom shall we make your accounts payable? _____

I have read and understand Beyond Smiles Privacy Policy. I understand that payment is required on the day of treatment.

My preferred method of payment is:

☐ Cash ☐ EFTPOS ☐ Credit Card

*Patient/Guardian Name/Signature :*_____ *Date :* _____

Failure to give 48 hours notice for appointment changes may incur a cancellation fee.

CONFIDENTIAL HEALTH INFORMATION

Name of your general Medical Doctor : _____ Phone : _____

Address : _____

Are you being treated for a medical condition at present? _____

Are you taking any medications or supplements at present, both prescribed or over the counter? (Please List)

_____

Do you have, or have you ever had, any of the following medical conditions?

High or low blood pressure	☐ Yes ☐ No	Leukaemia or cancer	☐ Yes ☐ No	Nervous or anxiety conditions	☐ Yes ☐ No
Heart ailments (valve problems, murmurs, pacemakers)	☐ Yes ☐ No	Radiation or chemotherapy	☐ Yes ☐ No	Eating disorders	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Organ or bone marrow transplants	☐ Yes ☐ No	Stomach or other bowel problems (ie. Reflux)	☐ Yes ☐ No
Excessive bleeding or blood disorders	☐ Yes ☐ No	Prosthetic implants	☐ Yes ☐ No	Hepatitis (A,B,C or other)	☐ Yes ☐ No
Asthma, chest of breathing problems	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Steroid therapy	☐ Yes ☐ No	Diabetes (Type I or Type II)	☐ Yes ☐ No
Bronchitis, emphysema or other lung diseases	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Other (Please Specify)	
Epilepsy	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No		

Do you have any allergies? (Penicillin, codeine, nickel, latex) ☐ Yes ☐ No

Please Specify : _____

Do you take any prescribed drugs, tablets, medicines, or creams? ☐ Yes ☐ No

Please Specify : _____

Have you ever been given medication for Osteoporosis or Osteoponeia? ☐ Yes ☐ No

Have you taken bisphosphonate medications? (Didronel, Fosamax, Aredia, Pamisol, Actonel, Zometa, Bonefos, Skelid or Bonviva) ☐ Yes ☐ No

How long have you been on the medication? _____ When did you last take them? _____

Have you even had any adverse reactions or allergic reactions to any treatment or medications? ☐ Yes ☐ No

Please Specify : _____

Do you have a heart murmur, or artificial heart valve? ☐ Yes ☐ No

Do you have any prosthetic body parts? (eg. Artificial hip shoulder or knee joints) ☐ Yes ☐ No

Please Specify : _____

Ladies, are you pregnant, undergoing fertility treatment or family planning? ☐ Yes ☐ No

If so, how many weeks?_____

Do you smoke? ☐ Yes ☐ No

If so, how many?_____

*Patient/Guardian Name/Signature :*_____ *Date :*_____