

Welcome to Smile Care Family Dentists. Making high quality dental more affordable for everyone.  
Please fill in this questionnaire with accuracy as we would like to get to know you.

Surname:		Title:	Given Name:	
Preferred Name:			Date of Birth:	
Address:		Suburb:		Postcode:
Home Phone:		Mobile:	Work:	
Email address:				
Name of Private Health Fund (if any)			Position No on card:	
Occupation:			Employer Name:	
<b>In case of an emergency whom should we contact?</b> Please indicate.				
Name:		Relationship:		Phone:
<b>Reminder System:</b> We remind our patients of their appointments. If you would like us to do this please indicate the preferred means of contact.				
<input type="checkbox"/> SMS to Mobile <input type="checkbox"/> Call mobile <input type="checkbox"/> Call home phone <input type="checkbox"/> Call work phone <input type="checkbox"/> Email				
<b>Email Updates:</b> Would you like to be kept informed with updates on what is new in the practice, services and new dental techniques that may be of benefit to you.				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Patient X-Rays:</b> Would you allow us to use your x-rays/images for ongoing patient education? Please note your name and/or any other personal details will remain disclosed.				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>How did you hear about us?</b>				
<b>Dental History</b>				
How long is it since your last thorough dental examination?				
<input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2years <input type="checkbox"/> 3 years <input type="checkbox"/> longer				
<b>Please tick any dental concerns you have?</b>				
<input type="checkbox"/> Toothache <input type="checkbox"/> Sensitive teeth <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Loose teeth <input type="checkbox"/> Bad breath <input type="checkbox"/> Dry mouth <input type="checkbox"/> Missing teeth		<input type="checkbox"/> Unsatisfactory denture <input type="checkbox"/> Rapidly decaying teeth <input type="checkbox"/> Lost filling/cavity <input type="checkbox"/> Grinding/clenching teeth <input type="checkbox"/> Worn, broken teeth <input type="checkbox"/> Pain in face or jaw joints <input type="checkbox"/> Sounds from joint		<input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Discoloured teeth <input type="checkbox"/> Appearance of teeth
<b>Medical History</b>				
Who is your general practitioner? _____			Telephone: _____	
<b>Have you had or are you suffering from any of these? (please tick)</b>				
<input type="checkbox"/> Heart Trouble <input type="checkbox"/> Cardiac Pacemaker <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Arthritis <input type="checkbox"/> Thyroid trouble		<input type="checkbox"/> Epilepsy <input type="checkbox"/> Sleep Apnoea <input type="checkbox"/> Stroke <input type="checkbox"/> Stomach Trouble <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Nervous Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Liver or kidney disease		<input type="checkbox"/> Excessive or prolonged bleeding <input type="checkbox"/> Radiation or chemotherapy <input type="checkbox"/> Eating disorder <input type="checkbox"/> Prosthetic implant/joint replacement <input type="checkbox"/> Organ or bone marrow transplant <input type="checkbox"/> Steroid therapy <input type="checkbox"/> Are you or could you be pregnant <input type="checkbox"/> Do you, or have you ever smoked? <input type="checkbox"/> Other (specify)_____
<b>Are you allergic to anything e.g. local anaesthetic, latex, penicillin, peanut, etc (please specify)</b>				
<b>What medications including natural remedies are you taking?</b>				

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian to sign if patient is a minor)