To assist us in providing the best dental treatment for you, please answer the questions relevant to you.

What is the reason for today's visit ? _____

What year was your last dental visit/Previous dentist's name: ?

_____

When was your last Exam / Scale / Clean ? _____

Have you had orthodontic treatment in past/orthodontist name?_____

Have you had any oral surgery/facial surgery/name of surgeon? _____

Are your teeth sensitive to ☐ Hot or Cold ☐ Sweets ☐ Biting or chewing ☐ N/A

Do your gums bleed when you clean your teeth ? _____

How often do you brush your teeth ? Once a day ☐ Twice a day ☐ Three times a day ☐ More ☐ _____

How often do you floss ? Everyday ☐ Sometimes ☐ Never ☐

Do you use a fluoride supplement ? If yes please list: _____

Are you aware of bad breath or a bad taste in your mouth ? Yes / No _____

Do you clench or grind you teeth while awake or asleep ? Yes / No _____

Do you drink tea or coffee ? _____ Smoke Cigarettes ? 10 ☐ 20 ☐ 30 ☐ More ☐

Would you like to change the appearance of your teeth ? Yes / No How ?_____

Would you like to make your teeth whiter or straighter ? _____

Do you feel that you need to close spaces or replace missing teeth ? _____

What is the most important thing to you about your smile ? _____

Have you had any Dermal/Facial Injectable in the past? If so with which clinic or practitioner? _____

_____

NOTICE TO INSURED PATIENTS REGARDING DENTAL BENEFITS INSURANCE

Item numbers on our statement represent as accurately as possible the procedures performed but in no way are they a claim on anyone other than the patient to whom they are performed. The eligibility of the patient, or the procedures, to attract refunds, and the rates of those refunds, are determined by the conditions of the patient's Health Insurance Policy.

DENTALSPA.COM PAYMENT POLICY

Payment is expected on the day of appointment. Private health claim facilities are available at reception. Balances can be settled using cash/chq, eftpos or credit card.

Outstanding accounts are sent to a debt collection agency of our choice, debt collection fees will be passed directly on to you, our patient.

PATIENT DECLARATION

I have completed the above questionnaire to the best of my knowledge and understand that the failure to make a full disclosure may place ME at undue medical risk.

Signed: _____ Date: _____

Print Name: _____

Checked by Dentist _____ Dentist signature _____

LIKE US ON FACEBOOK!
Level 2, 20 Little Ryrie Street, Geelong VIC 3220.
www.dentalspa.com.au email: info@dentalspa.com.au

dentalspa geelong

Commercial Services Award

PERSONAL & CONFIDENTIAL RECORD

To assist us in providing the best dental treatment for you, please answer the following questions as completely as possible.

DR ☐ MR ☐ MRS ☐ MS ☐ MISS ☐ MASTER ☐

SURNAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ PREFERED NAME: _____

Street Address: _____

Suburb/Town: _____ Postcode: _____

Telephone (Home): _____ Mobile: _____

Telephone (Work): _____ Email: _____

Occupation: _____ School/Employer: _____

Name of person responsible for fees: _____

Health Fund: _____ Membership No: _____ Number on Card: _____

Name of Doctor or Physician: _____ Telephone: _____

Emergency Contact: Name_____ Relationship to patient:_____ Telephone:_____

Have you had or have any of the following ? (please tick)

- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints (knee, hip etc.)
- ☐ Asthma
- ☐ Blood Pressure: High / Low
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Emphysema or other lung disease
- ☐ Epilepsy
- ☐ Excessive Bleeding/Blood Disorders
- ☐ Cancer/Leukaemia
- ☐ Heart Ailment (attack, disease, surgery)
- ☐ Heart Murmur
- ☐ Hepatitis A or C or B or Liver disease
  - ☐ HIV / AIDS
  - ☐ Kidney Disease
- ☐ Radiation or Chemotherapy
- ☐ Depression/ Anxiety
- ☐ Special Needs (AutismASD,Developmental Delay)
- ☐ Stroke or other CVA
- ☐ Tuberculosis
- ☐ Allergies: _____

Are you pregnant? Yes / No Due date (if expecting): _____

Have you been advised to take antibiotics before dental treatment? Yes / No

Are you presently under medical care or taking any prescribed or non prescribed medicines/tablets or inhalers ?

Yes/No (please list): _____

Who referred you to DentalSpa Geelong? _____

Are you aware that you snore? YES/NO

Do you wake feeling tired or fatigued? YES/NO