Welcome to Smart Choice Dental, where we take pride in the care we provide to our patients.
In order to provide you with the best dental treatment for your circumstances, we require information about your health status, and your personal contact details. This information is only used in conjunction with providing you with dental care. The information is stored in accordance with the relevant government legislation.

SMART CHOICE dental
look who's smiling now

PERSONAL INFO
Mr / Mrs / Miss / Ms / Miss / Mstr / Dr / Prof / other .....

Surname:.....…… First Name:.....…….. Middle Name:……

Date of Birth:..... Languages spoken (other than English) .....

Address:.....Suburb.....Pcode.....

Phone: Home:.....…..…….. Mobile:….....…..…..

Email:.....

CONTACTS IN CASE OF EMERGENCY

Emergency contact person ..... Phone .....

Your Employer:..... Your Work Phone number .....

for school age kids School name ..... Grade .....

HEALTH FUND

Extra's cover? YES / NO Name of fund ..... Single / Couple / Family

Level of cover (if known) .....

Approx date of last dental visit:.....

How did you hear about us? ....

If a friend recommended you to us, their name.....

MEDICAL HISTORY

Your medical history will be reviewed routinely in accordance with the Dental Practice Board of Victoria Guidelines.

Do you have a **history** (at any time) of the following? Circle all applicable.

RHEUMATIC FEVER	DIABETES	HIGH OR LOW BLOOD PRESSURE
EXCESSIVE BLEEDING	ARTIFICIAL HIP/KNEE/ANKLE	PACE MAKER
EPILEPSY	PENICILLIN ALLERGY	OTHER HEART RELATED AILMENTS
OSTEOPOROSIS	BONE PROBLEMS	THYROID PROBLEMS
STROKE	TUBURCULOSIS	ASTHMA
KIDNEY ISSUES	HEPATITIS /LIVER DISEASES	HIV/AIDS RELATED CONDITION

Have you **ever** suffered any other serious illness? Please give details and dates (at least the year)

SEE NEXT PAGE

Any Allergies?..... Adverse reactions to Anasthetics? .....

Are you presently receiving medical attention?

Details:……..…….....

Name and phone of your GP:…..…….……

Are you currently taking any medicines or tablets? Or in the last 12 months?

Details:……..…….....

Are you currently, or have you recently, undertaken any psychiatric treatment? YES / NO

Do you smoke? YES / NO How many per day ..... Drink Alcohol? YES / NO

Currently or in the past taken drugs of addiction? YES / NO

For women, are you pregnant? YES / NO Due date:……..…….....

LIFESTYLE *(optional questions)*

Do you snore? YES / NO Do you wake with sore jaws or pain in neck/shoulders? YES / NO

Do you suffer from Tinitis (ringing in the ears)? YES / NO Does your jaw click or crack? YES / NO

How many times a day do you brush your teeth? .....

What type of toothbrush do you use ? MANUAL / ELECTRIC which brand? .....

What type of tooth paste do you use NORMAL / SENSITIVE / OTHER .....

Do you floss? YES / NO If yes, how often? .....

Are you happy with your smile? .....

Have you ever considered undertaking teeth whitening? .....

Are you concerned about how your teeth will function in later life?.....

Do you have sensitivity to cold or hot on a regular basis? .....

If there was one thing you could change about going to the dentist, what would it be – anything!
.....

DECLARATION

It is important that the information given above are true and correct as it may affect the dental treatment options given to me. I hereby declare the above information is true, correct and complete. I also understand payment is required at the time of treatment by cash, Eftpos, major credit cards. I agree to pay for treatment I receive at Smart Choice Dental.

Client's signature:…….. Date:……

Dentist signature:…….. Date:……