Smile SOLUTIONS
MELBOURNE'S HOME OF DENTISTRY®

We ask you to provide the following pre-treatment information. The information we collect enables us to care for you better.

YOUR DETAILS

Title: Mr Mrs Ms Miss Dr (Other .....) Surname: .....

First Name: ..... Preferred Name: ..... Date of Birth: ...../...../.....

Home Address: .....

..... Postcode: .....

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

Email: .....

Please tick box if you do NOT wish to receive special promotions and communications via email ☐

How did you hear about our practice? .....

Do you belong to a health fund? **YES** ☐ **NO** ☐ Which one? .....

BUSINESS CONTACT

Occupation: ..... Work Phone: .....

Business Name & Address: .....

EMERGENCY CONTACT

Emergency Contact: ..... Contact No: .....

Relationship to You: .....

DENTAL & HEALTH INFORMATION

What is the purpose of your visit today? .....

Have you previously had any issues during dental treatment? **YES** ☐ **NO** ☐

If so, please explain: .....

Have you had any significant medical problems in the last 12 months? **YES** ☐ **NO** ☐

If so, please specify: .....

Name and address of your general medical doctor: .....

..... Contact No: .....

When did you last visit your doctor? .....

Please Turn Over

Do you currently, or have you ever suffered from any of the following conditions?

Please tick as appropriate	YES	NO		YES	NO
Arthritis	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Reflux or Frequent Vomiting	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Diabetes	☐	☐	Excessive Bleeding	☐	☐
Epilepsy or Fits	☐	☐	High or Low Blood Pressure	☐	☐
Angina	☐	☐	Anaemia	☐	☐
Disorder of Blood or Immune System	☐	☐	Tuberculosis	☐	☐
Hepatitis or Liver Disorder	☐	☐	Osteoporosis	☐	☐
Heart Attack, Heart Trouble	☐	☐	Depression or Psychiatric Conditions	☐	☐

Do you have any allergies? (e.g. penicillin, codeine, nickel, latex) **YES** ☐ **NO** ☐

If so, please specify: .....

Do you take any prescribed drugs, tablets, medicines or creams? **YES** ☐ **NO** ☐

If so, please specify: .....

Have you ever taken or been prescribed medication for Osteopoeneia or Osteoporosis? **YES** ☐ **NO** ☐

Do you take recreational drugs? **YES** ☐ **NO** ☐

Have you had any adverse reactions to any treatments or medications? **YES** ☐ **NO** ☐

If so, please specify: .....

Have you had radiation treatment to the head or neck? **YES** ☐ **NO** ☐

If so, when? .....

Do you have a heart murmur, or artificial heart valve? **YES** ☐ **NO** ☐

Do you have any prosthetic body parts? (e.g. artificial hip or knee joint) **YES** ☐ **NO** ☐

If so, please list: .....

Ladies, are you pregnant or family planning? **YES** ☐ **NO** ☐ If so, how many weeks? .....

Do you smoke? **YES** ☐ **NO** ☐ If so, how many? .....

Are you interested in having straighter teeth? **YES** ☐ **NO** ☐

Are you interested in having whiter teeth? **YES** ☐ **NO** ☐

Are you interested in therapeutic/cosmetic injectables for jaw dysfunction/TMD, anti-ageing, facial enhancement? **YES** ☐ **NO** ☐

I acknowledge that Smile Solutions will rely upon the information contained in this form. If the information provided in this form becomes out of date, I agree that I will provide Smile Solutions with updated information and I acknowledge that Smile Solutions may rely on that updated information. I warrant and represent that the information provided by me in this form and as updated by me from time to time is at all times accurate and complete. I have also read and understood the Smile Solutions Privacy Policy, which was provided to me.

I understand that I am responsible for my account and payment is required on the day of treatment. Registered specialists are not affiliated with any preferred provider program. Health funds such as Bupa, HCF and CBHS have a preferred provider network available for general dental care only. I understand that it is my responsibility to confirm the benefits payable for my proposed treatment directly from my health fund provider. I agree to accept liability of my treatment payment in the event that any third party claim is declined or is insufficient to fully cover the charges for treatment that may be declined. This includes and is not limited to TAC and WorkCover claims.

Print Name: ..... Signature: ..... Date: ...../...../.....

Failure to give 24 hours' notice for appointment changes may incur a cancellation fee.