# Sydney Aesthetic Smiles

MINIMUM INTERVENTION MAXIMUM RESULTS

**Please answer all questions and sign. All information is treated with complete professional confidentiality.**

**Are you confident filling out medical forms by yourself OR need a carer or interpreter? Please ask for our assistance.**

Title: O Mr O Mrs O Ms O Other ..... Birth Date: ...../...../.....

First Name(s): ..... (Preferred Name): ..... Family Name: .....

Address: ..... (Street).....(State)

..... (Suburb)..... (Postcode)

Contacts: ..... (Home Phone) Occupation: .....

..... (Work Phone) Preferred Language: .....

..... (Mobile) ..... ..... (Email)

Emergency Contact: ... ..... (Name)

... ..... (Home/Work/Mobile)

Who is your General Practitioner? ..... (Name/Suburb/Phone)

Do you have dental insurance? [ ] Yes [ ] No Provide r:..... ..... Member No.: ..... ID No.: .....

Accounts are settled on the day of treatment. What is your preferred method of payment?

O Cash O Credit Card O Eftpos O Finance O Cheque O Other .....

How do you usually travel to get dental/medical care, and how long does that journey typically take? .....

Do you have a physical/mental impairment? Please list .....

Is understanding written medical condition information difficult? [ ] No [ ] Yes

Any recognised deterioration in physical and/or mental cognitive health? Please list .....

Do you have access to dental/medical care? [ ] Yes [ ] No Are you Aboriginal or Torres Strait Islander? [ ] No [ ] Yes

Do you have any cultural or religious practices we should be aware of? .....

Do you or have you ever suffered from heart conditions or elevated blood pressure problems?

[ ] Yes [ ] No [ ] Hypertension/Blood Pressure [ ] Pacemaker [ ] High Cholesterol [ ] Irregular Heart Beat

[ ] Enlarged heart [ ] Rheumatic Fever [ ] Cardiac Surgery [ ] Heart Attacks [ ] Artificial Valves [ ] Murmur

[ ] Other .....

Have you ever had: [ ] any cancers [ ] radiotherapy [ ] chemotherapy ? .....

Any major hospitalisations? .....

Any allergies/rashes/hypersensitivities or adverse drug reactions ? [ ] No [ ] Yes

O Costume jewellery O Latex O Antibiotics O Iodine O Sulphur O Bee stings O Seafood O Nuts

O Other .....

Are you pregnant or possibly pregnant? [ ] No [ ] Yes (... .....months)

Do you suffer or have you ever suffered from: [ ] Diabetes [ ] Osteoporosis [ ] Anaemia [ ] Osteoarthritis

[ ] Nervous conditions/Anxiety/Depression [ ] Gastro Intestinal Disorders [ ] GORD [ ] Bulimia [ ] Epilepsy

[ ] High Cholesterol [ ] Thyroid problems [ ] Liver disease [ ] Kidney disease [ ] Asthma

[ ] Any other medical conditions .....

Do you have or have you ever had: [ ] Hepatitis A,B,C,D or E [ ] Meningococcal infections [ ] CJD [ ] Tuberculosis

[ ] Whooping Cough [ ] MRSA Methicillin Resistant Staph Aureus [ ] HIV/AIDS

[ ] Any other Infectious Diseases? .....

Please list ANY medications you are required to take prior to receiving treatment

.....

Please list ANY medications you are taking?

.....

.....

Do you use alcohol or other drugs to relax? .....

Have you ever injected illegal drugs? [ ] No [ ] Yes .....

Have you ever been: [ ] prescribed bisphosphonate medication e.g. Fosamax, Actonel, Bonviva?
[ ] treated for postmenopausal osteoporosis, Paget's Disease or metastatic bone disease arising from breast cancer?
[ ] Don't know

My last dental visit was: ..... and I am here today for: .....

[ ] check-up & clean [ ] 2nd opinion consultation/options [ ] treatment of pain [ ] swellings/infections
[ ] holes/broken teeth [ ] food traps [ ] loose teeth [ ] loose dentures [ ]sensitive teeth [ ] worn teeth
[ ] gum problems [ ] eating difficulties [ ] bad breath [ ] jaw joint problems[ ] headaches [ ] discoloured teeth
[ ] crooked/crowded teeth [ ] "aesthetics" [ ] Other: .....

The following are OPTIONAL QUESTIONS that are beneficial to your dental treatment.
How many times do you brush your teeth daily? [ ] 1 [ ] 2 [ ] 3 [.....] More
For how long? [ ] less than 1 minute [ ] 2 mins [ ] 3 mins [.....] mins
Do you clean between your teeth? [ ] Yes [ ] No
Do you clean your tongue? [ ] Yes [ ] No
How many teaspoons of sugar in a typical cup of tea/coffee? [ ] no sugar [ ] one [ ] more than one [.....]
Soft/sport/energy drinks? [ ]No [ ] a little [ ] a lot
Do you smoke? [ ] No [ ] a little [ ] a lot
Have you ever been told or do you think you: [ ] snore or [ ] grind your teeth while sleeping

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Your Health Information – Privacy Consent Form

Sydney Aesthetic Smiles respects your right to privacy. Disclosure of any information will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of your records at any time.

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SAS Financial Policy

Please read our financial policy below:

- Full payment is requested on the day of treatment. Health fund claims can be processed on the spot and Eftpos is also available.
- If health fund claims are rejected or disputed, we ask that health funds reimburse you following full payment of the account on the day of treatment. If this is not possible, patients are given a fortnight to settle any accounts pending or additional fees may be incurred.
- For patients who qualify, we offer payment plans through a third-party financing company (DentiCare) with interest free options.
- Do you have a regular source of income or financial support? .....
- We accept government aided vouchers authorised by the Oral Health Fee for Service Scheme (OHFFSS) and offer a payment plan facilitated by Denticare Payment Solutions.

Please speak to our staff if you are unsure about anything on this form.

- o I have read and accept the privacy policy above and have accurately completed the Medical/Dental History Form.
- o I consent to the performing of dental surgery procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures.
- o I am that payment is required on the day of treatment and I agree to settle my account on the day. (With the exclusion of Denticare and OHFFSS arranged).

Patient/guardian signature …….. Date ……..