



**Bondi** Shop 2, 110 Spring Street, near Bronte Road, Bondi Junct, NSW 2022 Ph 9389 3333 - 9387 3333 e bondi@classicsmiles.com.au

**Menai** Suite F, 101 Menai Central, Cnr Menai & Carter Rd, Menai, NSW 2234 Ph 9543 6666 - 9543 6667 e info@classicsmiles.com.au

## Welcome to Classic Smiles - fine cosmetic & implant dentistry

In order to provide treatment of high standard, it is necessary to have the following information which will be handled confidentially.

### Patient Details

Title:  Mr  Mrs  Miss  Ms  Dr  Other

Surname: ..... Given Name: ..... Occupation: .....

Company: ..... Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Private H/Fund: .....

Address: ..... Suburb: ..... P/Code .....

Ph: ..... Wk: ..... Mob: .....

E mail: .....

### EMERGENCY CONTACT

Name: ..... Tel (Home) ..... (Work) ..... Mobile: .....

### MEDICAL HISTORY (please tick which you have or have ever had)

Asthma  Rheumatic Fever  High Blood Pressure  Heart Attacks/Murmur

Pacemaker  Cardiac Surgery  Ulcer, Thyroid Disorder  Abnormal Bleeding

Epilepsy  Anaemia  Diabetes  Arthritis

Artificial Valve  Prostheses  Nervous Disorders  Previous Anaesthetic Problems

Osteoporosis  HIV/AIDS Positive  Hepatitis A,B,C or D

Other infectious diseases?  Yes  No Pregnant (due date) .....

Are you on Medication?  Yes  No If Yes please list .....

Have you ever taken bisphosphonate medications ?  Yes  No (Didronel, Fosamax, Aredia, Pamisol, Actonel, Zometa, Bonafos, Skelid or Bonviva)

Have you ever been treated for postmenopausal osteoporosis, Paget's disease of bone or metastatic bone disease arising from breast cancer?  Yes  No

**ALLERGIES:** ( Please tick )  Penicillin  Aspirin  Iodine  Sulpha

Other allergies .....

### DENTAL HISTORY

Reason for presenting to the surgery?  Consultation  Pain  Other .....

How did you hear about the practice?  Passing By  Referred  Advertisement

Have you ever had a difficult tooth extraction or experience prolonged bleeding?  Yes  No

Are you happy with the shape/look/colour and alignment/spacing of your teeth?  Yes  No

Would you like a comprehensive treatment plan with the best dentistry has to offer?  Yes  No

Do you suffer from headaches/neck pain/ clicky jaw/sleep apnoea etc?  Yes  No

How long ago was your last check-up and clean? .....

Do you consent to photos taken by the dentist being used for training/teaching purposes?  Yes  No

### THIS PRACTICE REQUIRES FULL PAYMENT ON THE DAY OF TREATMENT

How will you be paying?  C/Card  Cash  Cheque  Eftpos  V/A

Patients Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_\_\_