Sparkling Dental

6/ 27-35 Grosvenor St Neutral Bay NSW 2089
+61 2 9953 0088
www.sparklingdental.com.au
info@sparklingdental.com.au

ACQUAINTANCE FORM

Welcome to our practice. Please take the time to answer these questions as completely as possible. This will assist us greatly in our efforts to provide the best dental treatment for you. Thank You.

NAME: Title: _____ Given Names: _____ Surname: _____

Preferred Name:_____ Date of Birth:_____/_____/_____

Occupation: _____ Employer: _____

ADDRESS:

Home Address: _____

_____Postcode:_____

Postal address (if different): _____

Emergency Contact Person: _____

Relationship: _____ Phone: _____

PHONE NUMBERS:

Mobile: _____

Work : _____

Home: _____

Email: _____

How did you hear about us? _____

Do You Have Dental Health Insurance? _____ Name of Health Fund: _____Line No: _____

Is another member of your family a patient of our practice? _____

We remind our patients of their appointments – please indicate the preferred means of contact:

□ SMS to mobile □ CALL moblie □ EMAIL

MEDICAL HISTORY	NO	YES	COMMENTS
Have you ever had **Heart** trouble, heart surgery, Rheumatic Fever, Epilepsy or high blood pressure?			
Have you ever had Diabetes, Hyperthyroidism, Asthma, Glaucoma, nervous disorders, Anaemia, Bone disorders or Tuberculosis			
Have you ever had **Cancer** or any other **serious illness**? Radiation treatment or Chemotherapy?			
Have you been a patient in **Hospital** during the past two years?			
Are you under current **medical treatment?**			
Do you **Smoke**? How many per day?			
Are you taking any **drugs or medicines?** Please list: Name and Dosage			
Are you taking (or have you ever taken) **Prolia**, **Aredia**, **Zometa**, **Fosamax** or **Actonel** (usually for Osteoporosis)?			
Do you normally take **Antibiotics** prophylactically before a dental appointment?			
Do you have **artificial hips, knees, heart valves or pacemakers?**			
Have you any known **Allergies** to drugs (especially **penicillin**), medicines, antiseptics, injections or **Latex** ? **Dairy** allergy?			
Have you ever experienced prolonged **bleeding?** Do you take **Blood Thinners including Warfarin**, **Xarelto**, **Pradaxa Eliquis**, **Aspirin**, **Clexane**, **Plavix**, **Persantin**			

Have you had, or do have **Hepatitis** or **AIDS?**			
MEDICAL HISTORY	**NO**	**YES**	**COMMENTS**
Have you ever had **Kidney, Liver** or **Stomach** disease?			
Women: Are you, or might you be, **Pregnant?**			
Who is your General Medical Doctor?			Phone No:

DENTAL HISTORY	**NO**	**YES**	**COMMENTS**
Does **food catch** between your teeth?			
Do your **gums bleed** when brushing?			
Are you experiencing any **sensitivity** - hot, cold, sweet, chewing or biting pressure?			
Do you have any **bad taste** or odours in your mouth?			
Do you have any concerns with the **appearance of your teeth or their colour?**			
Do you feel you **clench** or **grind** your teeth?			
Does your **jaw click** or hurt?			
Do you **snore** during sleep?			
Have you had **orthodontic** treatment (braces) in the past?			
When was your last dental visit?			

List **previous problems** with Dental Treatment: _____

What is the **purpose of your visit** today? _____

Do you have any **incomplete treatment** from your previous dentist? _____

Any further **comments or special requests**? _____

_____

Person responsible for **payment today**? _____

Privacy All personal and health information will be treated confidentially in accordance with the Health Records and Information Privacy Act 2002 (NSW). This includes advising all treating practitioners and specialists of relevant medical and dental conditions.

Payment We appreciate payment at time of service. We accept all major credit cards, personal cheques, and cash. Where an overdue account is referred to a collection agency or other legal representatives, you accept liability for all costs/fees incurred. You agree that any partial payments will be first allocated to offset collection costs and charges in priority to the outstanding debt.

Missed Appointment Fee **A fee is charged for an appointment missed without 24 hours prior notice.**

Signature_____ Date _____/ _____/ _____