Greetings! We are pleased to welcome you to our practice.
*Please take a few minutes to fill out **both sides** of this form as completely as you can.*
If you have any questions please do not hesitate to ask. We look forward to working with you in maintaining your Dental Health.

Name: _____ Date of Birth: ____/____/_____
(Title) (First Name) (Surname)

Address: _____
(Street No. and Name) (Suburb) (Postcode)

Phone (H): _____ Mobile: _____ Phone (W): _____

Email Address: _____@_____
Please note: Your email address will only be used to send your Continuing Care 6 monthly appointment reminder

Occupation: _____

Emergency Contact Name: _____ Contact: _____ Relationship: _____

How did you find out about us? Internet / Signage / Yellow Pages Online / GlamSmile / Yellow Pages Directory
Other _____ / Existing Patient Name _____

Are you in a Health Fund? Yes / No

Fund Name: _____ Membership Card Number: _____ Position on Card: _____

Are you a Smile Member? Yes / No Membership Card Number: _____ Expiry Date: ____/____

Medical History

When was the last time you visited the Dentist? _____ When was the last time you had Dental X-Rays? _____

Have you ever had any problems or after effects following Dental treatment? Yes / No
If yes please explain: _____

Are you being treated by a Doctor at present? Yes / No If so, for what condition: _____

Please list any medications: _____

Do you normally require antibiotics before Dental Treatment? Yes / No

Are you taking any type of Bisphosphonate or Denosumab medications (for Osteoporosis treatment)? Yes / No

Do you have any allergies? (Sulphur, Penicillin, Latex etc): _____

Ladies, might you be pregnant? Yes / No If so, how many months: _____ Are you nursing: Yes / No

Indicate which of the following you **have ever had**, or **have at present**:
Please indicate by circling Yes or No to <u>each</u> item.

Rheumatic fever	Yes	No	H.I.V/Aids	Yes	No
Heart disorders	Yes	No	Liver Disease eg. Hepatitis	Yes	No
Epilepsy/Seizures	Yes	No	Asthma	Yes	No
High blood pressure	Yes	No	Bleeding Problems	Yes	No
Low blood pressure	Yes	No	Radiation Therapy	Yes	No
Thyroid Disease	Yes	No	Osteoporosis	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Kidney Disease	Yes	No	Fainting or dizzy	Yes	No
Tuberculosis	Yes	No	Prosthetic Implant	Yes	No
			Are you a smoker?	Yes	No

Any other Medical conditions: _____

Please Turn Over

Dental History

Please help us better understand your Dental Health needs and goals by answering the following questions:

1. I have a ( ) low ( ) moderate ( ) high fear of going to the Dentist.
2. My mouth and teeth are ( ) very comfortable ( ) moderately comfortable ( ) not comfortable.
3. I am ( ) very satisfied ( ) satisfied ( ) dissatisfied with the appearance of my teeth.
4. I think my present state of Dental Health is ( ) excellent ( ) good ( ) fair ( ) poor.
5. I would say that my main concerns with my dental health are: _____

Please tick which statement below ***best represents the level of dental health*** you wish to achieve**:**
(Some people begin at one level and progress to a higher level over time)

( ) HEALTH LEVEL I - Emergency Care

I am only interested in emergency Dental Care for the relief of pain and /or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

( ) HEALTH LEVEL II - Maintenance Care

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of Dental Care due to limitations of time and or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my Dental Health may not remain stable over time.

( ) HEALTH LEVEL III - Comprehensive Care

I am interested in Comprehensive Care to achieve and maintain a higher level of Dental Health. I am concerned about treating the causes of Dental diseases, not simply the effects. I want all Dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable Dental Health.

( ) HEALTH LEVEL IV - Cosmetic Care

I am dissatisfied with the appearance of my teeth and would like cosmetic dentistry to improve the aesthetics of my teeth.

Authorisation & Consent

1. I understand the above information is necessary to provide me with Dental Care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the Dentist of any change in my health or medication.

2. I hereby authorise Dr Cassimatis, and his staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my Dental needs.

3. I also give my permission for Dr Cassimatis and his staff to use this material for educational and promotional purposes. *(Please cross out if you do not consent to this)*

4. Upon such diagnosis, I authorise Dr Cassimatis and his staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

5. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

6. I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of service unless other arrangements have been made.

7. I understand that specific time is exclusively reserved for me when I make an appointment. I will provide a two-business days notice if I need to change an appointment. I understand that I will be charged a **$60.00** fee for failed appointments and changes in schedule without sufficient notice.

8. I give permission for Brisbane Smile Centre to contact me via phone, SMS, mail and email in regarding my appointments, continuing care 6 monthly reminders and dental treatment only.

Patient Signature: _____ ***Date: ____/____/_____***