Suite 212, 40 Yeo St
Neutral Bay NSW 2089
(02) 9904 2880
www.cosmicsmile.com.au

Please note that all information on this medical/dental form will remain strictly confidential.

Surname_______________________________________ Title________________________

Given Names________________________________ Date of Birth _____________________

Home number________________________________ Work Number____________________

Mobile number____

Email____ Fax ___________________

Home address____

Preferred method of contact ☐ Phone ☐ Email ☐ SMS

Occupation____

If the patient is a minor please note below the name of the parent or guardian completing this form

Surname______________________________________ Title_________________________

Given Names____

Female patients: Are you pregnant? ______________ How many Months? ______________

Have you had any serious illnesses? ____

If yes please indicate: ____

Are you currently taking any medications or tablets regularly? Eg. Aspirin, Bisphosphonate

If yes please indicate: ____

Do you have any allergies to Nickel, Adrenalin, Penicillin or other drugs? ______________

Is your blood pressure normal, high or low? ______________________________________

Do you smoke? ___________________________ How many per day? __________________

In case of an emergency please contact:

Name: ___________________________________ Phone number: ______________________

Have you ever had any of the following? Please tick those that apply to you:

☐ Heart Disease	☐ Osteoporosis	☐ Epilepsy
☐ Rheumatic fever	☐ Tumours or cancers	☐ Stroke
☐ Pacemaker	☐ Radiation Therapy	☐ Blood disease
☐ Heart Murmur	☐ Chemotherapy	☐ Botox, Dermal fillers
☐ Artificial joints	☐ Thyroid disorder	☐ Excessive bleeding
☐ High/Low BP_________	☐ Sinus problems	☐ Liver disease
☐ Endocarditis	☐ Respiratory problems	☐ Fainting / Dizziness
☐ HIV/AIDS	☐ Asthma	☐ Kidney disease
☐ Hepatitis: Type_______	☐ Diabetes	☐ Contact Dermatitis
☐ Tuberculosis	☐ Psychological problems	☐ Other - specify___________

Referral Information

Whom may we thank for referring you to our practice? ________________________________

If not a direct referral please circle: ☐ Other - please indicate _____________________

☐ Internet ☐ Website ☐ Facebook ☐ Yellow pages ☐ Phone book ☐ Newspaper ☐ Walked past

Are you concerned about any of the following dental problems?

- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Bad taste

- ☐ Sensitivity when eating or hot/cold
- ☐ Food trapping between your teeth
- ☐ Tooth sore or loose
- ☐ Tooth missing or has moved

- ☐ Discoloured fillings
- ☐ Roughness of any existing fillings
- ☐ Staining of your teeth

- ☐ Head/neck ache
- ☐ Grinding or clenching your teeth
- ☐ Clicking or pain in the jaw joints

Are you concerned with: -

- ☐ The appearance of your teeth
- ☐ Existing crowns, bridges or dentures
- ☐ Ability to eat
- ☐ Cleaning techniques e.g. brushing & flossing
- ☐ Your smile
- ☐ Snoring

Dental Values:

What's important to you about your teeth?
Please rate on a scale of 1-10

Tooth health	1←------------------→10
How preventive (proactive)	1←------------------→10
Tooth cosmetics	1←------------------→10

What is the main purpose of your visit? ____

____

____

How long since your last dental visit? ____

Does dental treatment make you nervous? ☐ No ☐ Moderately ☐ Slightly ☐ Extremely

Do you also feel you require:

☐ Gas (Nitrous oxide-laughing gas) ☐ Intravenous sedation ☐ General Anaesthesia

Consent for services

- This is to certify that I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a fee of $200 will incur if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs* at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment.

Signature of patient (parent or Guardian): ________________________ Date: _______________

* Identity will not be revealed