cosmic Smile laser dental

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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 _____ Fax _____

Email _____

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 _____

Name of your Doctor: _____ Phone number: _____

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

Have you had any serious illnesses? _____

Are you currently taking any medications or tablets regularly? eg. aspirin, bisphosphonates, blood pressure medication, antidepressants, blood thinners etc. If yes please indicate:

_____

Do you have any allergies to latex, Penicillin or other drugs? _____

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 / Stroke	□ Osteoporosis	□ Epilepsy
□ Rheumatic fever	□ Tumours or cancers	□ Stroke
□ Pacemaker	□ Radiation Therapy	□ Blood disease
□ Heart Murmur	□ Chemotherapy	□ Anaemia
□ 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	□ Other - specify_____
□ Tuberculosis	□ Psychological problems	

Referral Information

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

If not a direct referral please circle: Other - please indicate _____

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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 / ear ache
- □ Grinding or clenching your teeth
- □ Clicking or pain in the jaw joints
- □ Numbness or pain

Are you concerned with: -

- □ The appearance of your teeth / your smile
- □ Existing crowns, bridges, implants or dentures
- □ Ability to chew or swallow
- □ Cleaning techniques e.g. brushing & flossing
- □ Mercury 'Amalgam' fillings
- □ Snoring / daytime tiredness / poor sleep / CPAP

Are you Proactive or Reactive? (circle one)

Please rate on a scale of 1-10

Teeth health (keeping teeth)	1----------10
Function (ability to eat/drink)	1----------10
Cosmetics (white/straight/looks)	1----------10
Comfort (lack of sensitivity/pain)	1----------10

What is the main purpose of your visit? _____

_____

How long since your last dental visit? _____

(Please circle)

What is your biggest obstacle to visiting a dental office? None Fear Time No Urgency Budget No Trust

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