THIS IS your smile

smilestudio
personalised dental care

ALL DETAILS DISCLOSED REMAIN CONFIDENTIAL

CONTACT DETAILS

First Name…… Last Name…….…… Title……
Preferred Name…… Occupation……..……..…….. DOB…...……...
Address ……..……..
Phone…… Mobile……
Would you like to receive information about upcoming promotions at iSmile? Yes / No
Email……..……
Next of Kin……. Phone……..…… Relationship..……
Private healthfund……..…… Membership No……..……
Who can we thank for referring you? ……..…… Relationship……

To help us achieve your ultimate dental experience, please answer the following questions:

What would you like to achieve from your visit today?……..……
What did you enjoy most about your last dental experience?.....
If you could have improved your last dental experience, what would you have changed?
……..……

HEALTH & LIFESTYLE

Have you been hospitalised in the last 5 years? Yes / No If yes, reason……
Do you have trouble sleeping or experience tiredness/fatigue?. ……..……

Do you have, or have you ever had any of the following? (Please provide details below)

- ☒ Heart Condition / Surgery
- ☒ Respitory Problems
- ☒ Osteoporosis
- ☒ Arthritis/Joint Replacement
- ☒ Hepatitis A / B / C
- ☒ High / Low Blood Pressure
- ☒ Psychiatric Care
- ☒ Smoker
- ☒ Cardiac Pacemaker
- ☒ Stroke
- ☒ Diabetes
- ☒ HIV/AIDS
- ☒ Rheumatic Fever
- ☒ Epilepsy / Seizures
- ☒ Depression
- ☒ Leukemia
- ☒ Cancer Therapy
- ☒ Excessive Bleeding
- ☒ Coldsores or Ulcers
- ☒ Kidney Disease
- ☒ Allergies (list below)
- ☒ Acid Reflux

Female patients, are you pregnant or suspect you may be? Yes / No How far along? ……....
Do you have any other medical concerns, medications or supplements that we should know about?.....
……

PAIN MANAGEMENT

Location of current discomfort: ☒ Teeth ☒ Jaws ☒ Gums ☒ Head / Neck ☒ Other
Type of discomfort: ☒ Sharp ☒ Dull ☒ Throbbing
What makes it better?.....What makes it worse ……

HERE COMES THE SMILE

Have you had a breath analysis before? Yes/ No Have you had tooth whitening before? Yes/ No
What three things would you like to change about your teeth? 1) …… 2) ……3) ……
Do you wear: ☒ Retainers ☒ Splint ☒ Dentures ☒ Sports Mouthguard

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I will advise the practice to any future changes to the above

information. I also understand notes, x-rays or models relating to my treatment may need to be sent to other practitioners to aid them in my treatment, and give my permission for this to occur when necessary.

Signed: **Date:**