iSmileStudio
SMILE IN CONFIDENCE

patient form

Contact details

First name

Last name

Preferred name | Title

Occupation | DOB

Address

Phone | Mobile

Email

☐ I would like to receive news and updates from iSmileStudio via email

Next of kin | Phone | Relationship

Who can we thank for referring you? | Relationship

Private Health fund | Membership No | Patient number

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

- ☐ Heart condition/surgery
- ☐ Cardiac pacemaker
- ☐ Leukemia
- ☐ Respiratory problems
- ☐ Stroke
- ☐ Cancer therapy
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Excessive bleeding
- ☐ HIV/AIDS
- ☐ Cold sores or ulcers
- ☐ Hepatitis A/B/C
- ☐ Rheumatic fever
- ☐ Kidney disease
- ☐ Epilepsy/seizures
- ☐ High/Low blood pressure
- ☐ Arthritis/joint replacement
- ☐ Psychiatric Care
- ☐ Depression
- ☐ Acid Reflux
- ☐ Smoker
- ☐ Allergies *please list*
- ☐ Other

ALL DETAILS DISCLOSED REMAIN CONFIDENTIAL

Just a few more questions

Medications or supplements that we should know about?

Female patients, are you pregnant or suspect you may be? ☐ Yes ☐ No How far along?

Pain management

Location of current discomfort: ☐ Teeth ☐ Jaws ☐ Gums ☐ Head/Neck Other

Type of discomfort: ☐ Sharp ☐ Dull ☐ Throbbing Other

Here comes the smile

Have you ever had dermal fillers or Botox Treatment? ☐ Yes ☐ No

Have you had tooth whitening before? ☐ Yes ☐ No

Do you wear: ☐ Retainers ☐ Splint ☐ Dentures ☐ Sports Mouthguard

Smile evaluation

We want to meet your needs and can help with all the following issues.
Please tick any that concern you and hand this form to a member of the team.

- ☐ I don't like the appearance of my teeth
- ☐ My teeth aren't all in alignment (straight)
- ☐ I have gaps in between my teeth
- ☐ My dentures are uncomfortable, and they look/feel like dentures
- ☐ My teeth are not as bright and white as I would like them to be
- ☐ Some of my teeth are dark, chipped and misshapen
- ☐ I have missing teeth I would like to replace
- ☐ I have old silver fillings that I would like replaced with tooth coloured ones
- ☐ My gums bleed when I brush them
- ☐ I am concerned about the cost of treatment and how to pay for it

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 / /

☐ I give permission to iSmileStudio staff to take photos of me for use in social media and marketing.