smile forever®
Dental

New Client Form

Welcome to Smile Forever Dental. In delivering the best possible dental health care, it is important that you accurately complete the following details.

All medical questions asked are relevant to dental treatment. If you have any queries or concerns, please do not hesitate to ask your dentist.

PERSONAL DETAILS

Mr/Mrs/Ms/Miss/Dr/Mast Date of Birth_____

Full Name _____

Email Address _____

Address _____

Tel Home _____ Mobile No _____

Occupation _____

Employer _____ Tel Work _____

Work Address _____

How did you hear about Colin Street Dental? _____

(If it was a friend who referred you, please let us know as we like to personally thank them)

What prompted you to call us?_____

Are you a member of a health fund? Yes ❑ No ❑ Name of Fund_____

Membership Number: _____ Patient Number on card: _____

Would you like information on bleaching? Yes ❑ No ❑

MEDICAL HISTORY

Please circle Yes or No for any of the following:

Asthma	*Yes*	*No*	Rheumatic Fever	*Yes*	*No*
Heart disorder/attacks	*Yes*	*No*	History of high blood pressure	Yes	*No*
Pacemaker/ Cardiac Surgery	*Yes*	*No*	Thyroid Disorder	*Yes*	*No*
Diabetes	*Yes*	*No*	Epilepsy	*Yes*	*No*
Ulcer/Hiatus Hernia	*Yes*	*No*	Bronchitis	*Yes*	*No*
Radiotherapy/Chemotherapy	*Yes*	*No*	Artificial Joints/Heart Valves	*Yes*	*No*
Tuberculosis	*Yes*	*No*	Abnormal Bleeding	*Yes*	*No*
Fainting Spells	*Yes*	*No*	Stomach/Digestive Problems	*Yes*	*No*
Kidney Problems	*Yes*	*No*	Pregnant (Due Date)	*Yes*	*No*
Recently been in Hospital?	*Yes*	*No*	Hepatitis A B or C	*Yes*	*No*
Any Disease related to AIDS	*Yes*	*No*	HIV Positive	*Yes*	*No*

ALLERGIES: PENICILLIN SULPHA ASPIRIN IODINE OTHER _____

Are you on medication? If yes, please list

GP Details: (Name, Address/Suburb) _____

- **All accounts are due at the completion of every visit.**

- Please provide the surgery with at least **24 hours** notice if you are unable to keep your appointment. This will enable us to better manage your appointments and help you avoid a missed appointment fee. Payment for your treatment is accepted at the completion of each appointment. Any administration or debt recovery costs incurred in the recovery of outstanding amounts will be at your expense.

Client's Signature_____ **Date**_____