



acquaintance form

Dear Patient Welcome to our office!

Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Patient Name: _____ Date: _____
 Birth Date: _____ Male Female Married Single Child Other
 Preferred Name: _____ Email: _____
 Phone (Home): _____ (Work): _____ (Mobile): _____
 Address: _____
 Employer: _____ Occupation: _____
 Preferred Method Of Contact : Phone Email SMS
 How did you hear about our practice : _____
 Are You In A Health Fund : No Yes - If Yes Which One? _____

This section is essential to us in providing safe medical treatment:

Do you have any of the following? Please Tick

- | | | | |
|--|------------------------------------|--|---|
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Healing Complications | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis:Type _____ |
| <input type="checkbox"/> Sulphur Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recurrent Headaches | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other Allergy _____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |

Are you, or could you be pregnant? Yes No

Do you smoke? Yes No

Are you currently taking any medications or other drugs? Yes No

If yes, please state? _____

Dental History

What is your present dental concern _____

How do you feel about keeping your natural teeth _____

When was your last dental appointment _____

a. Health

Are you concerned about or experiencing any of the following

- | | |
|---|--|
| <input type="checkbox"/> Sensitivity to hot, cold, sweets or pressure | <input type="checkbox"/> Decay or broken teeth |
| <input type="checkbox"/> Bleeding gums, loose teeth | <input type="checkbox"/> Ability to eat |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food catching between teeth |
| <input type="checkbox"/> Gum recession | |



b. Function

Are you experiencing any of the following

- Clicking or pain in the jaw joint
- Snoring or sleep apnoea
- Head, neck or shoulder pains
- Missing teeth
- Grinding or clenching of your teeth

c. Cosmetics/Aesthetics

Are you dissatisfied with you teeth and their appearance. Yes No

Is there anything you would like to change about your smile _____

Are you concerned particularly about any of the following

- Crooked, misaligned, crowded teeth
- Missing teeth
- Discoloured, stained, yellow teeth
- Old fillings
- Spaces or gaps between your teeth
- Discoloured fillings
- Worn teeth
- Old veneers, crowns, bridges, dentures
- Gummy smile
- Wrinkles around you eyes, brow, forehead, cheeks, lips or chin

Policies of Practice and Consent for Services

1. Payment for services is expected on the day of treatment
2. We offer a variety of Finance Options (for approved applicants) including interest free terms and extended payment terms to commence treatment sooner
3. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. There is no relationship between the doctor and the health fund. Any relationship with an insurance company is between the patient and their health fund.
4. A 48 hour notice is required if there are any changes to appointment times given to you. Failure to do so will incur a charge of \$200.00.

Preferred method of payment: Cash Cheque Credit Card Eftpos

I Herby Consent Do Not Consent to the use of study models, x-rays, computer imaging and photographs* at various dental seminars that Dr Shah delivers or publications that he may author.

*Identity will not be revealed

To the best of my knowledge, all of the preceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I understand that all health information given, will be treated with privacy and confidentiality. I have read the above conditions of treatment and agree to their content.

Signature: _____ Date: _____