

# 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: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other
Preferred Name: _____		Email: _____	
Phone (Home): _____	(Work): _____	(Mobile): _____	
Address: _____			
Employer: _____		Occupation: _____	
Preferred Method Of Contact : <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> SMS			
How did you hear about our practice : _____			
Are You In A Health Fund : <input type="checkbox"/> No <input type="checkbox"/> 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? \_\_\_\_\_

Are you experiencing tooth sensitivity to any of the following ?

- Heat  Cold  Sweets  Biting Pressure

Does food catch between your teeth?  Yes  No

Do your gums bleed when brushing?  Yes  No

Do you have an unpleasant taste or odour in your mouth?  Yes  No

When was your last dental appointment? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

What is your present dental concern? \_\_\_\_\_

Would you like us to discuss tooth whitening with you?  Yes  No

Are you dissatisfied with your teeth and their appearance?  Yes  No

How do you feel about keeping your natural teeth? \_\_\_\_\_

Would you like to change anything about you smile? \_\_\_\_\_

### Responsible Party Information

The following information is for the person responsible for payment.

Relationship To Patient:       Self       Spouse       Parent       Guardian       Other \_\_\_\_\_

**If the responsible party is other than self, please complete the following. Otherwise, please refer to the next section.**

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_  Male     Female

Phone (Home): \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Consent For Services

This practice depends upon reimbursement from our patients for the costs incurred in their case. Financial responsibility on the part of each patient must be determined before treatment. As a condition of your treatment by this office, financial arrangements must be made in advance.

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.

Payment for services is expected on the day that treatment is rendered.

We also offer a variety of Finance options\* including interest free terms & extended payment terms to commence treatment sooner

\*Finance options are available to approved applicants

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: \_\_\_\_\_