



**Integrated Smiles**  
General Dentistry Implants & Orthodontics

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We are pleased to welcome you to our surgery. The following information is necessary to enable us to provide you with the best dental care. All information is strictly confidential.

**Your Details**

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Residential Address: \_\_\_\_\_  
 Postal Address: \_\_\_\_\_  
 (Please circle preferred contact) Email address: \_\_\_\_\_  
 Phone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

**Your Emergency Contact/Family Details**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Your Medical History**

Name of your GP: \_\_\_\_\_ GP Contact Details: \_\_\_\_\_

**Please Circle if you have had or are suffering from any of the following? Yes (Y) or No (N)**

Cardiovascular problem (shortness of breath, heart attack, stroke, angina)				Y	N
Rheumatic Fever, Heart Murmur, Inborn Heart Defect.				Y	N
Artificial Joint, Heart Valve or Prosthetic Implant.				Y	N
High Blood Pressure	Y	N	Low Blood Pressure	Y	N
Diabetes (circle Type I or II)	Y	N	Asthma/Breathing Problem	Y	N
Stomach/Bowel Problems (eg Ulcer)	Y	N	Tuberculosis	Y	N
Kidney Disease	Y	N	Thyroid or Endocrine	Y	N
Excessive Bleeding or Blood Disorder	Y	N	Epilepsy or Seizures	Y	N
Hepatitis	Y	N	AIDS/HIV	Y	N
Cancer or Tumor	Y	N	Radiation Treatment	Y	N
Bone Disorders or Disease	Y	N	Chemotherapy	Y	N
Rheumatoid or Arthritic Condition	Y	N	Acid Reflux	Y	N
Anaemia or Fainting (circle either)	Y	N	Creutzfeldt-Jacob Disease	Y	N
Special Care or Learning Disability	Y	N	Mental Condition	Y	N
Are you pregnant	Y	N	Anticipating Pregnancy	Y	N
Smoker	Y	N			

Please list details if you have ticked yes to any of the above: \_\_\_\_\_  
 \_\_\_\_\_

Please list any allergies, including medicines and products (eg, Penicillin, Latex): \_\_\_\_\_  
 \_\_\_\_\_

Please list all medications that you are taking: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Your referral details:** How did you hear about our office? **Please Tick**

- Facebook       Radio       Location       Google/Website  
 Friend       Family       Work Colleague       Yellow Pages       Other

Thank you for noting down name of referee so that we can thank them \_\_\_\_\_

**Account Details:**

Please note that we ask for payment on the day of treatment. Eftpos and Hicaps are available.

Who is responsible for settling the account? \_\_\_\_\_

Name of health insurance fund if applicable? \_\_\_\_\_

**How we can help you with your oral health concerns: Your Dental History**

What have you come to see us for today? \_\_\_\_\_

How would you like us to help you? \_\_\_\_\_

Does dental treatment make you nervous? \_\_\_\_\_

Note down any problems that you have had with dental treatment in the past? \_\_\_\_\_

Is there anything that you would like to discuss with the dentist in private? \_\_\_\_\_

**Do you have concerns with any of the following? Please CIRCLE** Yes (Y) or No (N)

Bleeding Gums or Bad Breath	Y	N	Trouble with Brushing or Flossing	Y	N
Discoloured Teeth or Fillings	Y	N	Chipped or Broken Teeth	Y	N
Worn Down Teeth	Y	N	Tooth Grinding or Clenching	Y	N
Jaw Clicking or Hurting	Y	N	Snoring or Sleep Apnoea	Y	N
Teeth Sensitive to hot/cold	Y	N	Loose Teeth	Y	N
Missing Teeth/Gaps	Y	N	Ill-fitting Dentures	Y	N
Aesthetics or Appearance of Teeth	Y	N	Difficulty in Chewing/Jaw Opening	Y	N

**Orthodontic treatment**      *We now offer a comprehensive orthodontic treatment range. If you are interested in orthodontic treatment please tick boxes below to the following:*

Have you ever had a prior orthodontic examination or treatment?      Y      N

Have you ever had or are suffering from any of the following?

Spaced Teeth or Gaps      Y      N      Crooked Teeth      Y      N

Protruding Teeth      Y      N      Tongue Thrusting      Y      N

Thumb or Finger Sucking Habit      Y      N      Until what age? \_\_\_\_\_

History of Speech Problems      Y      N      Mouth Breathing      Y      N

Treatment for TMJ (jaw joint)      Y      N      Pain in Head or Neck Region      Y      N

**Thank you for your assistance in completing this form as fully as possible.**

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 also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

**So that we can serve you better, do you consent to quarterly email newsletters and occasional offers and updates?**      Y      N

**Date:** \_\_\_\_\_

**Signed:** \_\_\_\_\_