smileconcepts
implant . cosmetic . general dentistry

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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: _____ Prefered Name: _____ Occupation: _____

Address: _____

Phone(Home): _____ (Work): _____ (Mobile): _____

Email: _____ Prefered Method Of Contact : ☐ Phone ☐ Email ☐ SMS

Are You In A Health Fund : ☐ No ☐ Yes - If Yes Which One? _____

How did you hear about our practice : _____

What made you choose us : _____

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

Do you have any of the following? Please Tick

☐ Codeine Allergy	☐ Asthma	☐ Healing Complications	☐ Heart Murmur
☐ Penicillin Allergy	☐ Cancer	☐ Excessive Bleeding	☐ Hepatitis:Type
☐ Sulphur Allergy	☐ Diabetes	☐ Recurrent Headaches	☐ High Blood Pressure
☐ Other Allergy	☐ Dizziness	☐ Radiation Treatment	☐ Kidney Disease
☐ Anaemia	☐ Epilepsy	☐ Respiratory Problems	☐ Liver Disease
☐ Arthritis	☐ Fainting	☐ Tuberculosis	☐ Hay Fever
☐ Artificial Joints	☐ HIV	☐ Rheumatic Fever	☐ 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 you present dental concern? _____

How do you feel about keeping your natural teeth? _____

When was your last dental appointment? _____

Do you think saving your teeth is worth the effort? _____

Have you had any trouble with previous dental treatment? _____

Do you desire complete and thorough dental care or treatment of a specific problem only?

Have you had regular preventive dental care in the past?

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a. Health

Are you concerned about or experiencing any of the following

- ☐ Sensitivity to hot, cold, sweets or pressure
- ☐ Bleeding gums, loose teeth
- ☐ Bad breath
- ☐ Gum recession
- ☐ Decay or broken teeth
- ☐ Ability to eat
- ☐ Food catching between teeth
- ☐ Wisdom teeth problems

Have you even been told you have gum disease? _____

b. Function

Are you experiencing any of the following

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

c. Cosmetics/Aesthetics

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

If you could change anything about your smile, what would it be? _____

_____

Do you care if metal fillings show? _____

Are you concerned particularly about any of the following

- ☐ Crooked, misaligned, crowded teeth
- ☐ Discoloured, stained, yellow teeth
- ☐ Spaces or gaps between your teeth
- ☐ Worn teeth
- ☐ Gummy smile
- ☐ Missing teeth
- ☐ Old fillings
- ☐ Discoloured fillings
- ☐ Old veneers, crowns, bridges, dentures

d. Dento-Facial Aesthetics

We provide a global approach to your health, wellbeing and aesthetics (looks). We can offer treatments that can revitalise your entire face to achieve optimal beauty & proportions when undergoing treatment.

Are you concerned particularly about any of the following

- ☐ Forehead wrinkles
- ☐ Wrinkles around eyes
- ☐ Wrinkles in the brows
- ☐ Eyebrow shape
- ☐ Wrinkles under eyes
- ☐ Cheek volume, position, shape
- ☐ Skin hydration, laxity, texture
- ☐ Chin volume, position & shape
- ☐ Bands down the neck
- ☐ Shape of nose

Submit Form