ACQUAINTANCE FORM

Title (please circle): Mr Mrs Dr Ms Miss

Patient Name (in full): _____

Home Address:_____

Occupation: _____ D.O.B._____/_____/_____

Phone Numbers: Home: _____ Mobile: _____

Work: _____ Email: _____

How did you hear about North Shore Dentistry?_____

Emergency Contact: Name: _____Phone Number: _____

Health Fund: Do you have a Dental Health Fund? _____ Name of Fund:_____

Account: Name & address of person responsible for the account

_____

ALL ACCOUNTS ARE TO BE SETTLED AT THE END OF EACH APPOINTMENT. PLEASE ASK OUR PRACTICE MANAGER ABOUT PAYMENT PLANS FOR LARGER ACCOUNTS.

We remind our patients of their appointments. Please tick your preferred means of contact:

Home Phone ☐ Work Phone ☐ Mobile ☐ SMS to Mobile ☐ Email ☐

MEDICAL HISTORY

Name of your GP: _____ Phone: _____

Address: _____

What is the main purpose of your visit today? _____

Why did you leave your last dentist? _____

How long since your last dental visit?_____How often do you visit the dentist?_____

How often do you brush your teeth? _____How often do you floss? _____

What other aid do you use? (Piksters, toothpick, etc.) _____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Females, are you pregnant? Yes / No

Have you ever smoked? Yes/ No If yes, how many per day? _____

North Shore Dentistry
1311 Pacific Hwy, Turramurra NSW 2074
P: (02) 9449 9366
E: reception@northshoredentistry.com.au

Have you ever had or are currently suffering from any medical conditions?

Are you taking any medications? If yes, please provide details:_____

Have you ever had an adverse reaction to local anaesthetics or other medications?

_____

Have you ever had Botox™ or dermal fillers?_____

Do you snore or have you been diagnosed with sleep apnoea?_____

Do you have any cosmetic dental goals? i.e. Whiter Teeth, Straighter Teeth?_____

Terms of Acceptance

1/. All dental treatment is carried out using the latest techniques, equipment and materials. All equipment is either disposable or sterilised using an autoclave which is validated daily for optimal efficiency.

2/. It is the policy of this practice to take diagnostic radiographs (x-rays) at the first examination and specific radiographs (x-rays) as required before certain procedures.

3/. Any treatment required will be provided with the patient's informed consent after all risks associated with the treatment are outlined.

4/. All information on this form is considered confidential and is necessary to ensure that the best possible treatment can be provided.

5/. Each appointment made is a contract between North Shore Dentistry and the patient. All appointments cancelled with less than 24 hours notice will incur a $100 cancellation fee to help cover costs.

6/. An estimate of fees for treatment should be outlined prior to treatment being provided. If you are not sure of estimated fees, please let our Practice Manager or your Dentist know.

7/. All fees incurred per appointment must be settled at the completion of that appointment, unless a payment plan has been create with your Dentist or the Practice Manager.

8/. Dishonoured cheques will incur a $50.00 dishonour fee.

9/. Should any account for any reason become outstanding, then the patient, or person responsible for accounts, will be responsible for all debt collection charges incurred.

10/. Should any photographs be taken of you, please confirm if you are happy for these to be used for:

Research Purposes: Face ☐ Teeth Only ☐ Marketing Purposes: Face ☐ Teeth Only ☐

I _____ confirm that the medical history provided is a true indication of my health at this time, I also agree to the terms set out above.

Signed _____ **Date_____/_____/_____**

North Shore Dentistry
1311 Pacific Hwy, Turramurra NSW 2074
P: (02) 9449 9366
E: reception@northshoredentistry.com.au

North Shore™ Dentistry
HEALTHY SMILES FOR LIFE

ADA AUSTRALIAN DENTAL ASSOCIATION INC.