The Family Smile

440 Tapleys Hill Road
Fulham Gardens SA 5024
T 08 8356 0555
F 08 8356 9856

Dr / Mr / Mrs / Ms / Miss .....

Address ..... Suburb .....

Date of Birth ..... Phone ..... Mobile .....

Occupation ..... Email .....

Health Fund ..... Payment Method Cash ☐ EFTPOS ☐ VISA / Mastercard ☐

Please mark your current medical conditions -

AIDS	☐	Bleeding Problems	☐	Epilepsy	☐	Pregnancy	☐
Allergies	☐	Blood Pressure	☐	Heart Disorder	☐	Radiation Head/Neck	☐
Asthma	☐	Diabetes	☐	Hepatitis	☐	Rheumatic Fever	☐

Have you had any of these medications -

Actonel ☐ Alendro ☐ Botox ☐ Didronel ☐ Fosamax ☐ Zometa ☐

Have you had IV or oral bisphosphonate therapy? Yes ☐ No ☐

Any current medication(s) .....

Any other relevant conditions? .....

Medical Doctor ..... Phone .....

Have you had dental X-rays in the last 2 years? Yes ☐ No ☐ Are you a smoker? Yes ☐ No ☐

Please mark if you are concerned with / interested in -

Ability to eat	☐	Crows feet / smile lines / wrinkles	☐	Previous dental treatment	☐
Bad breath	☐	Discolouration of teeth	☐	Silver fillings	☐
Bleeding gums	☐	Existing bridges, crowns, dentures	☐	Teeth whitening	☐
Clenching / grinding	☐	Lip fullness	☐	Teeth cleaning techniques	☐
Crooked teeth	☐	Missing teeth or gaps	☐	Your smile	☐

Who referred you to The Family Smile? .....

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated. I can ask for a complete recital of any possible complications and will assume responsibility for the fees associated with those procedures.

I am aware that payment is required on the day of and at least 24 hours notice for cancellation of any appointment is required and a cancellation fee of $50.00 may be incurred if I fail to do so.

The Family Smile provides as a courtesy to our patients a preventative recall program that contacts patients if they have not visited the practice in six months.

Signed ..... Date .....