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ACQUAINTANCE FORM

In order to ensure dental treatment of the highest standard, it is necessary to have the following information, which will remain strictly confidential. Please complete this form in **print.**

Name:_____ Date of Birth:_____
Title First Name Surname

Address:_____

Telephone: Mobile_____ Home_____ Work_____

E-mail Address: _____

Emergency Contact Details: Name:_____ Phone:_____

Do you belong to a Private Health Insurance Fund?_____ If yes, which one?_____

Member Number_____

At Genuine Smiles there are times we may need to send appointment confirmations to our patients. If you would like this service please indicate your preferred method of communication from our practice:
E-mail◯ SMS◯ Call mobile◯ Call home◯

Who may we thank for referring you to our practice?_____
If not a direct referral, how did you hear about our practice?_____

MEDICAL AND DENTAL HISTORY

Name of your Family Doctor:_____ Your Doctor's Phone Number:_____

Please list any Specialist doctors that you have been under the care of in the last 5 years:

Specialist Doctor	Contact details	Condition Treated	Date of Treatment

Are you taking any prescribed medication? Yes / No
If yes, please list: Name Dosage

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking any complementary medicines? Yes / No
If yes, please list: Name Dosage

_____ _____
_____ _____

Do you smoke? Yes / No If yes, how many per day?_____

Are you taking bisphosphonates for osteoporosis or Paget's disease (e.g. Fosamax)?_____Yes / No
Do you take any recreational drugs?_____Yes / No
Do you drink alcoholic beverages? Yes / No If yes, how much did you drink in the last 24 hours?_____
Women Only: Are you pregnant?_____Yes / No
Breastfeeding?_____Yes / No

Allergies – Are you allergic to or have you had a reaction to:

Local anaesthetics	Yes / No	Aspirin	Yes / No
Penicillin or other antibiotics	Yes / No	Sulfur drugs	Yes / No
latex (rubber)	Yes / No	Food (if yes specify) _____	Yes / No
Iodine	Yes / No	Other (if yes specify)_____	Yes / No

Have you had any of the following diseases or problems?

Artificial (prosthetic) heart valve	Yes / No	Previous infective endocarditis	Yes / No
Congenital Heart disease	Yes / No	Cardiovascular disease	Yes / No
Angina	Yes / No	Arteriosclerosis	Yes / No
Congestive heart failure	Yes / No	Damaged heart valves	Yes / No
Heart Attack	Yes / No	Heart murmur	Yes / No
Low blood pressure	Yes / No	Mitral valve prolapse	Yes / No
Pacemaker	Yes / No	Rheumatic fever	Yes / No
Rheumatic heart disease	Yes / No	Abnormal bleeding	Yes / No
Anemia	Yes / No	Blood Transfusion	Yes / No
Hemophilia	Yes / No	AIDS or HIV infection	Yes / No
Arthritis	Yes / No	Autoimmune disease	Yes / No
Rheumatoid arthritis	Yes / No	Systemic lupus erythematosus	Yes / No
Asthma	Yes / No	Bronchitis	Yes / No
Emphysema	Yes / No	Sinus trouble	Yes / No
Tuberculosis	Yes / No	Chronic pain	Yes / No
Cancer/chemotherapy/radiation treatment	Yes / No	Severe headaches/migraines	Yes / No
Diabetes Type I or II	Yes / No	Eating disorder	Yes / No
Gastrointestinal disease	Yes / No	GE Reflux/persistent heartburn	Yes / No
Ulcers	Yes / No	Thyroid disease	Yes / No
Stroke	Yes / No	Glaucoma	Yes / No
Hepatitis, jaundice or liver disease	Yes / No	Epilepsy	Yes / No
Fainting spells or seizures	Yes / No	Neurological disorders	Yes / No
Sleep disorder/sleep apnoea	Yes / No	Mental health disorder	Yes / No
Recurrent infections	Yes / No	Kidney problems	Yes / No
Osteoporosis	Yes / No	Sexually transmitted disease	Yes / No

Other (if yes specify)_____Yes / No

Have you been a patient in hospital during the past two years?_____Yes / No
Have you ever experienced prolonged bleeding?_____Yes / No
Have you ever had a difficult tooth extraction?_____Yes / No
Do your gums bleed when you brush or floss?_____Yes / No
Are your teeth sensitive to cold, hot, sweets or pressure? _____Yes / No
Does food or floss catch between your teeth?_____Yes / No
Is your mouth dry?_____Yes / No
Have you had any periodontal (gum) treatments?_____Yes / No
Have you ever had orthodontic (braces) treatment?_____Yes / No
Have you ever had any problems associated with previous dental treatment?_____Yes / No
Do you ever have earaches or neck pains?_____Yes / No
Do you have any clicking, popping or discomfort in the jaw?_____Yes / No
Do you brux or grind your teeth?_____Yes / No
Do you snore at night?_____Yes / No
Do you wake up in the morning feeling tired and unrefreshed?_____Yes / No

Do you have sores or ulcers in your mouth?_____Yes / No
Have you ever had a serious injury to your head or mouth?_____Yes / No
Date of your last dental exam:_____
What was done at that time?_____
Date of last dental x-rays:_____
What is the reason for your dental visit today?_____
_____

YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY

Our practice respects your right to privacy. It is important that you understand the purpose, for which we collect details about you and your health, as well as how this information is used at our practice and to whom this information might be disclosed. **More detailed information is set out in our Privacy Policy**. If you would like a copy of the policy please ask our staff.

The information we collect will be used for the purpose of providing treatment to you. Personal information such as your name, address, telephone numbers, email address and health insurance details will also be used for the purpose of billing and processing payments.

Unless required to do so by court order or other legislative requirement, we will only collect, use and disclose your health information for the purposes of assessing, advising and treating you.

Your patient history, treatment records, x-rays and any other material relevant to your treatment are kept in our electronic clinical information systems. We have security measures in place to protect this information against unauthorized access or use and damage, theft or other loss.

It is important that the information we hold about you remains accurate. Please advise our staff if your contact details change. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Please sign below to confirm that:

1. You have read this information;

2. You agree to our collecting, using and disclosing your information in this way;

3. You are aware that payment is required on the day of treatment;

Name: _____ Date: _____

Signature: _____