

ACQUAINTANCE FORM

To ensure dental treatment of the highest standard, it is necessary we have the following information. It will remain strictly confidential. Please complete this form in **print**.

Title	First Name	Surname	
Date of Birth	Email Address		
Address			
Suburb			Postcode
Home Ph.	Work Ph.	Mobile No.	
Emergency Contact Details: Name:		Phone:	
Private Health Insurance Fund Name: Number:	Member Number:	Series	

At Genuine Smiles there are times we may need to send you appointment confirmations. Please indicate your preferred method(s) of communication from our practice:

Email 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 Treatment	Contact details	Condition Treated	Date	of
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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
_____	_____	_____
_____	_____	_____

Allergies: (please circle answer)			
Aspirin	Yes	Penicillin or other antibiotics	Yes
Sulfur drugs	Yes	Latex (rubber)	Yes
Iodine	Yes	Other (please specify)	

Have You OR Do You Have Any of The Following? (please circle answer)			
Rheumatic fever/Endocarditis	Yes	Osteoporosis	Yes
No		No	
Heart problems	Yes	Severe headaches/migraines	Yes
No		No	
Stroke	Yes	Sleep disorder/sleep apnoea	Yes
No		No	
High Blood Pressure	Yes	HIV	Yes
No		No	
Asthma	Yes	Autoimmune disease	Yes
No		No	
Lung problems	Yes	Hepatitis A B or C	Yes
No		No	
Diabetes	Yes	Transplants	Yes
No		No	
Thyroid problems	Yes	Joint replacements	Yes
No		No	
Tuberculosis	Yes	Epilepsy	Yes
No		No	
Bleeding problems	Yes	Mental health disorder	Yes
No		No	
Cancer/chemo/radiation treatment	Yes	Depression/Anxiety	Yes
No		No	
Reflux	Yes	Other (please specify)	
No			

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	
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 orthodontic (braces) treatment?	Yes
No	
Do you have any clicking, popping or discomfort in the jaw?	Yes
No	
Do you clench 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	
Women Only: Are you pregnant or breastfeeding?	Yes
No	
When did you last visit the dentist:	
What is the reason for your dental visit today?	

Please tick any of the following that apply to you or if you wish to disclose any of the below. Multiple can be ticked if multiple apply.

- I identify as being of Aboriginal and/or Torres Strait Islander origin
 - I have a disability
 - I come from a culturally or linguistically diverse background
 - I am from a non-English speaking background
 - I am under 18 years of age
 - I live in a rural or remote area
 - I am from a low socio-economic background
 - I have difficulty reading, writing, or understanding written information
 - I am over the age of 65
 - I am medically compromised
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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: _____