



A Better Smile Dental Spa

General and Cosmetic Dentistry

Registration Form

For your convenience, and to save you valuable time, please complete the information and either Email it or PRINT OUT and bring the page(s) to our office.

Name _____ D.O.B. ____/____/____

Address _____

City _____ Suburb _____ Post Code _____

Phone (H) _____ Phone (W) _____ Mobile _____

E-Mail _____

Do you have Health Insurance Y / N Health Found Name _____

Employer _____

Responsible I Party Information (If Child under 18)

Name _____ Relationship _____

Phone (H or Mb) _____

How did you find out about Us? _____

Instructions:

Check "NO" if the question does not apply to you. Do not leave a question unanswered.

Heart conditions Y / N

Are you required to PRE-medicate before your appointments? Y / N

Artificial joint, vascular grafts, artificial heart valve? Y / N

Abnormal blood pressure, excessive bleeding, or anemia? Y / N

Breathing problems, asthma, tuberculosis, hayfever, sinusitis? Y / N

Cancer, x-ray treatments, or chemotherapy?	Y / N
Diabetes?	Y / N
Hepatitis, jaundice, or liver disease?	Y / N
Kidney problems or renal dialysis?	Y / N
HIV positive or AIDS?	Y / N
Do you smoke, use "snuff" or chew tobacco?	Y / N
Allergic reaction to medications?	Y / N
Have you ever had a major operation?	Y / N
If yes, describe: _____	
For women: Are you pregnant?	Y / N

Dental History

Are you having pain or discomfort at this time?	Y / N
Do you feel very nervous about having dental treatment	No 0 - 1- 2- 3- 4- 5 Very
How long ago was your last visit to a dentist? _____	
In respect to any previous dental treatment have you: Ever had a bad experience in the dental office?	Y / N
If yes, describe: _____	
Does food catch between your teeth?	Y / N
How often do you brush each day? _____	
Do you floss?	Y / N
Are any of your teeth sensitive to heat, cold or pressure?	Y / N
Do you grind your teeth or clench your jaws?	Y / N
Do you have pain or clicking in the jaw joint around your ear	Y / N
Do any of your teeth ache?	Y / N

Are you happy with the way your teeth look? Y / N

Do you wear dentures, if yes, do they cause pain or problems? Y / N

Medical History Warning

Warning: Anesthetics and other medications that may be necessary in your dental treatment may interact with prescriptions, over-the-counter drugs and medications, and illicit drugs. Please make sure forms are completed accurately. These interactions may be serious and fatal! You must inform the doctor of all drugs and medications you are now, or have ever taken. You must also disclose if you are a recovering alcoholic or drug user. All information will be held in the strictest confidence and will not be disclosed without your prior approval.