SYDNEY WISDOM TEETH
CENTRE FOR SURGERY

Suite 403, Level 4 307 Pitt St. Sydney NSW 2000
t 02 9267 7777 f 02 9264 1371
e info@sydneywisdomteeth.com.au

acquaintance form

Dear Patient Welcome To Our Office!

Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Patient Name: _____ Date: _____

Birth Date: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Prefered Name: _____ Email: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

Address: _____

Employer: _____ Occupation: _____

Prefered Method Of Contact : ☐ Phone ☐ Email ☐ SMS

How did you hear about our practice : _____

Are You In A Health Fund : ☐ No ☐ Yes - If Yes Which One? _____

This section is essential to us in providing safe medical treatment:

Do you have any of the following? Please Tick

☐ Codeine Allergy	☐ Asthma	☐ Healing Complications	☐ Heart Murmur
☐ Penicillin Allergy	☐ Cancer	☐ Excessive Bleeding	☐ Hepatitis:Type
☐ Sulphur Allergy	☐ Diabetes	☐ Recurrent Headaches	☐ High Blood Pressure
☐ Other Allergy	☐ Dizziness	☐ Radiation Treatment	☐ Kidney Disease
☐ Anaemia	☐ Epilepsy	☐ Respiratory Problems	☐ Liver Disease
☐ Arthritis	☐ Fainting	☐ Tuberculosis	☐ Hay Fever
☐ Artificial Joints	☐ HIV	☐ Rheumatic Fever	☐ Other

Are you, or could you be pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you currently taking any medications or other drugs? ☐ Yes ☐ No

If yes, please state? _____

Dental History

What is you present dental concern? _____

How do you feel about keeping your natural teeth? _____

When was your last dental appointment? _____

Do you think saving your teeth is worth the effort? _____

Have you had any trouble with previous dental treatment? _____

Do you desire complete and thorough dental care or treatment of a specific problem only?

Have you had regular preventive dental care in the past?

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a. Health

Are you concerned about or experiencing any of the following

- ☐ Sensitivity to hot, cold, sweets or pressure
- ☐ Bleeding gums, loose teeth
- ☐ Bad breath
- ☐ Gum recession
- ☐ Decay or broken teeth
- ☐ Ability to eat
- ☐ Food catching between teeth
- ☐ Wisdom teeth problems

Have you even been told you have gum disease? _____

b. Function

Are you experiencing any of the following

- ☐ Clicking or pain in the jaw joint
- ☐ Head, neck or shoulder pains
- ☐ Grinding or clenching of your teeth
- ☐ Snoring or sleep apnoea
- ☐ Missing teeth

c. Cosmetics/Aesthetics

Are you dissatisfied with your teeth and their appearance. ☐ Yes ☐ No

If you could change anything about your smile, what would it be? _____

_____

Do you care if metal fillings show? _____

Are you concerned particularly about any of the following

- ☐ Crooked, misaligned, crowded teeth
- ☐ Discoloured, stained, yellow teeth
- ☐ Spaces or gaps between your teeth
- ☐ Worn teeth
- ☐ Gummy smile
- ☐ Missing teeth
- ☐ Old fillings
- ☐ Discoloured fillings
- ☐ Old veneers, crowns, bridges, dentures

d. Dento-Facial Aesthetics

We provide a global approach to your health, wellbeing and aesthetics (looks). We can offer treatments that can revitalise your entire face to achieve optimal beauty & proportions when undergoing treatment.

Are you concerned particularly about any of the following

- ☐ Forehead wrinkles
- ☐ Wrinkles around eyes
- ☐ Wrinkles in the brows
- ☐ Eyebrow shape
- ☐ Wrinkles under eyes
- ☐ Cheek volume, position, shape
- ☐ Skin hydration, laxity, texture
- ☐ Chin volume, position & shape
- ☐ Bands down the neck
- ☐ Shape of nose

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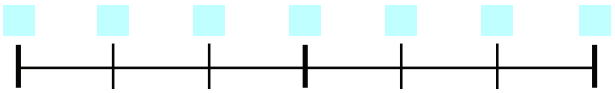
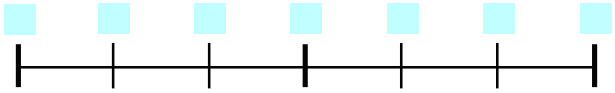
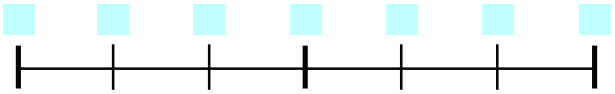
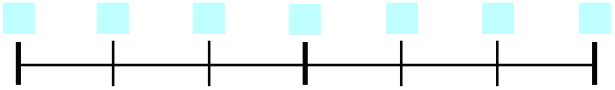
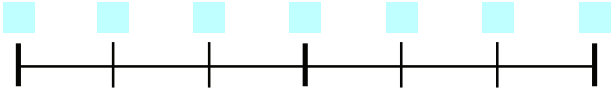
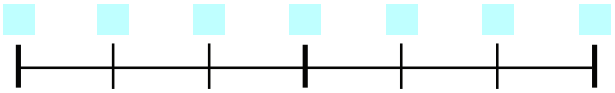
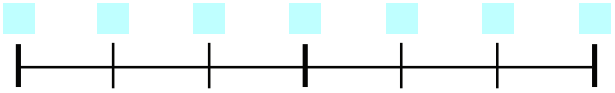
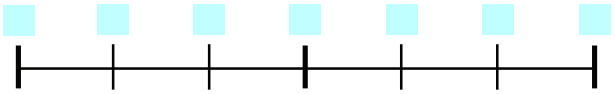
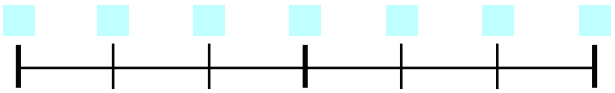
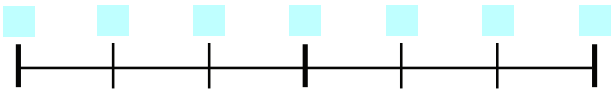
e. Sleep Problems

Do you have difficulty falling asleep ?	☐ Yes	☐ No
Do you wake up refreshed the next day ?	☐ Yes	☐ No
Do you often wake feeling tired ?	☐ Yes	☐ No
Do you have problems concentrating for long periods of time ?	☐ Yes	☐ No
Do you snore or have you been told you snore?	☐ Yes	☐ No

We would like to understand you better

The better we understand you, the better we can serve you. We don't like to make assumptions or guess about what makes you tick. Please make a mark along each scale below to indicate your opinion or preference.

I know a great deal about my dental condition		I know very little about my dental condition
I like to be presented with fewer options		I like to be presented with more options
I tend to look at the details		I tend to look at the big picture
I prefer long-lasting solutions which may cost more		I prefer more temporary solutions at lower cost
I prefer to talk in technical terms with my dentist		I prefer to talk in non-technical terms
My insurance largely determines the extent of my care		I largely determine the extent of my care
I prefer to wait until I must act		I usually see no reason to delay care
I rely more on self-maintenance		I rely more on professional maintenance
I like newer and more modern techniques		I prefer tried and true methods
I favor a treatment-oriented approach to disease		I favor a cause-oriented approach to disease

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In order of importance, I generally consider the following benefits (please rank 1 through 7 or 8):

_____ Comfort	_____ Appearance	_____ Peace of Mind
_____ Function	_____ Precision	
_____ Durability	_____ Health	_____ Other _____

In order of importance I generally weigh the following costs (please rank 1 through 5 or 6):

_____ Money	_____ Time	_____ Personal Effort
_____ Physical Discomfort	_____ Fear / Anxiety	_____ Convenience

Policies of Practice and Consent for Services

1. Payment for services is expected on the day of treatment

2. We offer a variety of Finance Options (for approved applicants) including interest free terms and extended payment terms to commence treatment sooner

3. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. There is no relationship between the doctor and the health fund. Any relationship with an insurance company is between the patient and their health fund.

4. A minimum of 72 hours notice is required (unless specified otherwise) if there are any changes to appointment times given to you. Failure to do so will incur a charge of $200.00.

Preferred method of payment: ☐ Cash ☐ Cheque ☐ Credit Card ☐ Eftpos

I Herby ☐ Consent ☐ Do Not Consent to the use of study models, x-rays, computer imaging and photographs* at various dental seminars that Dr Shah delivers or publications that he may author.

*Identity will not be revealed

To the best of my knowledge, all of the preceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I understand that all health information given, will be treated with privacy and confidentiality. I have read the above conditions of treatment and agree to their content.

Signature: _____ Date: _____