Welcome to Simply Dental

Thank you for choosing Simply Dental to support you in achieving great dental health and wellbeing.

As a new client you can expect our focus to be on what you need and want, in a way that works for you. This may mean sorting out some existing issues first – no worries, we will make this as easy a process as possible. We will then focus on keeping you healthy so you can enjoy having a great smile.

To begin, we'd like to know a little more about you. The following detailed dental and medical questionnaire will provide us with valuable information about how we can best help you.

Your first visit will focus on the following:

1. Understanding you and your dental history and current needs.
2. A comprehensive clinical assessment and diagnosis including digital X-rays (that we will show you and talk you through)
3. Detailed explanation and discussion of your clinical requirements
4. We will recommend a care plan and outline your payment options

Our Customer Care Commitments to You:

1. Positive and empowering dental experience – we focus on you and supporting you to get the most out of your smile,
2. Excellent communication and information that makes sense to you and is what you want,
3. No surprises– we'll tell you everything you need to know. We love helping people and want you to feel great about the process.

Our main goal is to support you to enjoy a healthy and happy life. We do this through empowering you to effectively look after yourself and providing the right type of dental care at the right time. This way we can help you avoid unnecessary dental issues, saving you time, grief and money!

We appreciate any feedback we receive. Our team is committed to on-going improvement and development to ensure your experience with us is outstanding.

We look forward to meeting you.

The team at Simply Dental

New Client Information

Personal Details

Name: First ______________________________Middle __________________________ Last_____________________________

Preferred name_______________________________________ DOB_________/____________/___________

Mobile ph ____Home ph____________________________________

Email/s____/ ____

Home Address: ____

____

Your Preferred Contact type:1. __________________________________ 2._____________________________________

Work Ph:____ Email____

Occupation____ Employer____________________________________

WINZ Card number ______________________________________ Expiry date________/________/__________

Emergency Contact Name________________________________Relationship__________________________________

Emergency Contact Ph. ____

Name of Previous Dental practice____

When was the last time you had a Dental check-up? ____

Medical Services

GP/Medical Practice enrolled with____

GP name: ____ Last visit: __________________________________

Do you use any other medical services? YES / NO If Yes, please provide name and contact details:

____

____

How did you find out about us?

Google Search ☐ Yellow pages ☐ Website ☐ Barter Card ☐

School ☐ which? ________________________ Referral ☐ from? ____________________

Other ☐_______________________________________

Payment Terms - Full *Terms of Trade* details are attached, please read.

Payment for your first visit is expected on the day, and for each session thereafter.

Administration fees may be incurred for late payment, failed or late cancellation of appointments (less than 24hrs notice).

Payment Method

I will pay for my care via (please tick) **Cash** ☐ **Eftpos** ☐ **Credit Card** ☐

Other Payment Options

Barter Card ☐ **WINZ Quote** ☐

Payment Plan Options – We can offer payment plans for dental care plans where needed, this should be discussed with the clinician. Normal credit criteria apply.

Please tick if you wish to discuss **Direct Debit** ☐ **Q.Card** ☐

I _________________________________ confirm that the above information is true and correct and have read and agree to the *Terms of Trade* for receiving dental care from Simply Dental

Signed: ____Date: _____/_____ /______

Thank you.

Client Health and Wellbeing Questionnaire

Please answer the following questionnaire regarding your Dental and Medical health to ensure we provide you with safe and appropriate dental care and achieve optimal results. We take privacy and confidentiality seriously and will not share or use your information without your permission.

Dental Health Questioannire

Are you happy with your teeth/oral health? Y/N If No, what would you most like to change?

1.

2.

3.

Do you have, or have you recently experienced, any of the following: *Office Use*

Pain/discomfort from anywhere inside your mouth?	Y / N	
Broken or chipped teeth/fillings?	Y / N	
Loose fillings/crowns/bridges?	Y / N	
Obvious holes and/or food trapping in your teeth?	Y / N	
Pain from your jaw joints or muscles of your jaw, head/neck?	Y / N	
Clicking or scraping noise from your jaw joint(s)	Y / N	
Pain or difficulty with opening your mouth wide, chewing food etc.	Y / N	
Fractured / broken teeth due to an accident?	Y / N	

Bleeding from your gums?	Y / N	
Hard or soft build-up on your teeth/around your gums?	Y / N	
Bad Breath (halitosis)?	Y / N	
Loose/wobbly teeth?	Y / N	
Gum recession?	Y / N	
Sensitivity of your teeth?	Y / N	
Teeth that have drifted/moved in recent times?	Y / N	
A history of having gum treatment/surgery/deep cleaning?	Y / N	

How would you rate your oral (mouth) health?	Good / Fair / Poor	
Are you concerned by the shape, colour or position of your teeth? **Please specify:**	Y / N	

SimplyDental
Smiling Together

Do you have missing teeth/gaps you are unhappy with?	Y / N	
Have you ever had to have a tooth removed due to decay, abscess or pain?	Y / N	
How regularly do you visit the dentist (approx.)? What is the main reason for your dental visit? **E.g.** check-up, pain, clean…	6, 12, 18, 24 monthly Or? _____________	
Have you ever had pain from your wisdom teeth?	Y / N	
Have you had any wisdom teeth removed?	Y / N	
Have you ever had orthodontic treatment?	Y / N	
Do you feel anxious about visiting the dentist?	Y / N	
Have you had sedation for dental treatment in the past?	Y / N	
Would you be interested in sedation for dental treatment?	Y / N / Maybe	

If you have a denture or dentures:

How old is your denture(s) in years (approximately)?	1-5 6-10 11-20 20+	
Are the denture(s) comfortable?	Y / N	
Are the denture(s) loose or ill fitting?	Y / N	
Do the dentures move when you eat/talk?	Y / N	
Do the denture(s) trap food?	Y / N	
Are you happy with the look of your dentures?	Y / N	

Self-Care: Oral health at home

How often do you brush your teeth?	1x day, 2x day, most days, a few times a week, rarely	
What type of toothbrush do you use?	Manual/Electric	
The tooth brush bristles are…	Soft / Medium / Hard	
What toothpaste do you use?		
How often do you floss/clean between your teeth	Daily / 3-4 times week / 3–4 times a month/ rarely / never	
The drink I have most is….		
How often do you have drinks that contain sugar? (e.g. energy/fizzy drinks, juice, milo, hot chocolate, added sugar to tea/coffee?	4+ a day / 1-3 a day / 1-3 a week / rarely	
How often do you have high sugar foods or snacks? e.g muesli bars, dried fruits, biscuits, lollies, chocolate, flavoured yoghurts, cereals	4+ a day, 1-3 daily, 1-3 a week, 1-2 x per week, or other, please specify:	
Do you use any of the following oral health products (please circle):	Mouthwash Sugar free gum Tooth mousse Fluoride supplements (e.g. tablets)	

SimplyDental
Smiling Together

Medical Health Questionnaire

Have you ever been diagnosed and/or receiving any medical treatment from your GP, Hospital or health care provider for any of the following (please circle response)?

High Blood Pressure	Y / N	
Stroke, mini-stroke, blood clot (e.g. deep vein thrombosis)	Y / N	
Heart Attack?	Y / N	
Angina/chest pains?	Y / N	
Previous Rheumatic fever, heart murmurs or heart valve problems?	Y / N	
Do you take anything to thin your blood (e.g. Warfarin, aspirin etc.)?	Y / N	
Bleeding disorder/prolonged bleeding after surgery?	Y / N	
Anaemia?	Y / N	
Do you have an artificial joint (e.g. hip, knee)?	Y / N	
Asthma, Bronchitis or other chest problems?	Y / N	
Do you use an inhaler?	Y / N	
Tuberculosis?	Y / N	
Hepatitis A, B or C?	Y / N	
HIV?	Y / N	
Diabetes? Type 1 / Type 2 (please circle)	Y / N	
Stomach or digestive problems Liver problems?	Y / N	
Kidney Problems?	Y / N	
Epilepsy / history of fitting or faints?	Y / N	
Thyroid Problems?	Y / N	
Depression or anxiety?	Y / N	
Are you or do you think you may be pregnant? How many weeks pregnant? ____________weeks	Y / N	

Habits

Do you or have you recently been a smoker or use tobacco products?	Y / N	
Do you use recreational drugs? Please specify	Y / N	
Do you have a drug dependence?	Y / N	
Do you drink alcohol?	Y / N Approx. standard drinks per week:	

Are you currently taking any medications?	Y/N Please list:	
Do you take any supplements/natural remedies?	Y / N Please list:	
Have you ever had an allergic or bad reaction to any medications or drugs?	Y / N Please list:	
Are you allergic to anything else?	Y / N Please list:	

Thank you for taking the time to provide the above personal information. Is there anything else you feel we should know about your medical health or dental needs?