Acquaintance Form

www.LanapAustralia.com.au

LANAP AUSTRALIA
Laser Alternative to Gum Surgery

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: _____ **Preferred Name:** _____ **Occupation:** _____

Address: _____

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

Email: _____ **Preferred Method of Contact:** ☐ **Phone** ☐ **Email** ☐ **SMS**

Are You In A Health Fund: ◯ No ◯ Yes **If Yes Which One?** _____

How did you hear about our practice: _____

What made you choose us: _____

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?

_____

What is you present dental concern? _____

Are you concerned about or experiencing 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. Is there anything you would like to discuss or tell us?

Consent for Services

I consent to dental treatment which is necessary or advised to me and to which I agree to and assume responsibility for fees associated with the treatment undertaken.

I am aware that payment for services is required on day of treatment.

We would like to thank you for your response. We can ensure you that this information will remain confidential, it will not be collected or identified by government or health authorities. It will be used solely to protect ourselves and others.

SUBMIT FORM