Welome to our practice, you've made the right choice.

In order to provide you with the highest standard of dental care, we require you to complete the following questionnaire. If you are unsure about anything, please ask our staff for assistance.

Should your health condition or medication change at any time, please inform us.

All information will be treated confidentially.

personal information

title: _____ surname: _____ first name: _____

d.o.b ____/____/_____ occupation: _____ company name.: _____

address: (h) _____

_____

address: (w) _____

_____

tel: (h) _____ tel: (w) _____ tel: (m) _____

driver's licence no. _____ email _____

do you have dental health cover? ☐ yes ☐ no if yes, which fund? _____

were you referred to us by anyone? ☐ yes ☐ no if yes, by whom? _____

if not, how did you find us? _____

dental information

what is your main reason for attending today? _____

_____

Dr Lazaris teaches continuing education courses that often involve clinical case studies. Would you allow the use of your clinical records (including photographs and x-rays) to be used for these purposes?

Yes / No

The use of before and after photos are important patient educational tools and used as validation of the quality of our work. Would you allow the use of your clinical photographs to be used for educational and promotional purposes?

Yes / No

are you aware of any dental problems you may have or wish to discuss?

- ☐ Pain or sensitivity
- ☐ Cavities
- ☐ Cracked or fractured fillings
- ☐ Clenching or grinding
- ☐ Faulty or old fillings
- ☐ Discoloured teeth
- ☐ Missing teeth
- ☐ Wisdom teeth
- ☐ Poor sleep quality
- ☐ Worn down teeth
- ☐ Chipped or cracked teeth
- ☐ Headaches
- ☐ Jaw pain
- ☐ Crooked teeth
- ☐ Orthodontic
- ☐ Bleeding gums
- ☐ Receding gums
- ☐ Bad breath
- ☐ Loose or mobile teeth
- ☐ Gum health
- ☐ Gummy smile
- ☐ Difficulty eating or chewing
- ☐ Appearance of teeth
- ☐ Colour of teeth
- ☐ Ulcers/sores

are you interested in any of the following?

- ☐ Cosmetic dental options
- ☐ Invisalign clear braces
- ☐ White fillings
- ☐ Porcelain veneers
- ☐ Porcelain crowns
- ☐ Dental implants
- ☐ Replacing missing teeth
- ☐ Teeth whitening
- ☐ CEREC restorations
- ☐ Gum care
- ☐ Smile lift procedures
- ☐ Lip enhancement procedures
- ☐ Dermal fillers
- ☐ Jaw pain treatments
- ☐ Botox treatments

please turn over

dental history

Have you ever had:

Dental implants?	Yes / No
Orthodontic treatment?	Yes / No
Oral surgery?	Yes / No
Periodontal or gum treatment?	Yes / No
Your teeth ground or bite adjusted?	Yes / No
A bite plate or mouthguard?	Yes / No
A serious injury to the mouth or head?	Yes / No
Any previous problems with dental infections?	Yes / No

If so, please describe, including cause? _____

is there anything else about having dental treatment that you would like us to know? If yes, please describe:

_____

_____

medical history

please tick any of the following conditions that apply now or in the past.

☐ heart condition	☐ rheumatic fever	☐ liver problems/hepatitis	☐ asthma
☐ blood pressure	☐ diabetes	☐ arthritis	☐ emphysema
☐ prolonged bleeding	☐ cancer	☐ thyroid disorder	☐ headaches
☐ anaemia	☐ epilepsy	☐ nervous disorder	☐ other

details _____

_____

_____

are you currently under any medical treatment or observation? ☐ yes ☐ no

details: _____

_____

are you taking any medication, pills or drugs? ☐ yes ☐ no

details: _____

_____

do you have any allergies? ☐ yes ☐ no

details: _____

_____

females. are you pregnant? ☐ yes ☐ no

are you breast feeding? ☐ yes ☐ no

who is your physician?

_____

Suburb

_____

is there any reason to suspect that you may be at risk of having:

hepatitis?	☐ yes	☐ no
AIDS?	☐ yes	☐ no
other transmissible diseases?	☐ yes	☐ no

Terms and Conditions

Dr Angelo Lazaris practice does not issue accounts and full payment is required at the time of each appointment and at completion of the treatment.
It is usual practice policy that a 15% deposit is taken at the time of scheduling appointments greater than 150min.
Please note that we require a minimum of 48 hours notice in the event that an appointment needs to be rescheduled or cancelled.
Appointments cancelled or rescheduled with less than 48 hours notice do incur a fee of $220 per hour.

signature _____ date ____/____/____

office use

medical history update

_____

_____

_____