dentaltown

PATIENT HISTORY FORM

The following information is needed for your safety and to make your visit a positive experience. All information is kept confidential.

<table>
<tr><td colspan="2">Please circle Mr. Mrs. Miss. Ms.</td><td colspan="2">First Name:</td></tr>
<tr><td colspan="2">Preferred Name:</td><td colspan="2">Last Name:</td></tr>
<tr><td colspan="2">Date of Birth: / /</td><td colspan="2">Occupation:</td></tr>
<tr><td>Home Address:

Suburb:
Postcode:
State:</td><td></td><td>Postal Address:
(Leave if same as Home Address)
Suburb:
Postcode:
State:</td><td></td></tr>
<tr><td>Phone (H)
Phone (W)
Mobile</td><td>☐ ____________________
☐ ____________________
☐ ____________________

(Please tick your preferred contact)</td><td>How did you hear about us?

(Please circle):</td><td>Friend/Family (Name: ________________)
Google
Facebook
Radio
Flyer
Walked Past
Dentaltown Staff</td></tr>
<tr><td>Email:</td><td colspan="3">________________________ @ ___________________________</td></tr>
<tr><td colspan="2"><u>Emergency Contact</u>:
Name:
Relation:
Phone:</td><td colspan="2" rowspan="2"><u>Responsible for Fees</u> (leave if you are responsible):
Name:
Relation:
Phone:
Address:</td></tr>
<tr><td colspan="2">Health Fund (if you have one):

Health Fund Number:
________________ / _____</td></tr>
</table>

MEDICAL HISTORY

<table>
<tr><td>Name of your Medical Doctor: ______________________________
Tick if you <u>don't</u> have a regular Medical Doctor ☐</td><td>Phone:</td></tr>
<tr><td colspan="2">Your Doctor's Address:</td></tr>
</table>

Have you ever had any of the following? **(Please circle)**

Allergies (please note)	Yes No ____________		Gastric Reflux	Yes	No
Artificial heart valve	Yes	No	Excessive thirst	Yes	No
Complications at dentist	Yes No ____________		Liver disease	Yes	No
Heart Stents	Yes	No	Bulimia/Anorexia	Yes	No
Excessive bleeding	Yes	No	Hepatitis A, B, C	Yes	No
Asthma	Yes	No	Tuberculosis	Yes	No
Bone disease	Yes	No	AIDS/HIV	Yes	No
High blood pressure	Yes	No	Heart Ailment	Yes	No
Diabetes	Yes	No	Creutzfeldt-Jakob	Yes	No
Stroke	Yes	No	Epilepsy	Yes	No
Rheumatic fever	Yes	No	Kidney disease	Yes	No
Artificial hip or knee	Yes	No	Taken illicit drugs recently	Yes	No
Chance of pregnancy	Yes	No	Have you ever smoked?	Yes	No
Hypoglycaemia	Yes	No	Fainting/Dizziness	Yes	No
Cancer of any kind?	Yes	No	Frequent Cough	Yes	No
Radiation therapy	Yes	No	Ulcers	Yes	No
Thyroid disease	Yes	No	Emphysema	Yes	No
Congenital Heart disease	Yes	No	Mitral valve prolapsed	Yes	No
Have you been diagnosed as COVID-19 positive				Yes	No

Please list the details of your current medications (including over the counter medicines and complementary medicines):

Medication:	**Dosage:** (e.g. 50mg 2 times per day)	**Duration: (e.g. months/years)**	**Purpose:**

**Please write on back of page if medications exceed this table.*

DENTAL HISTORY

Are you experiencing dental pain right now? Yes No

If so, where (circle)?

Upper right Upper front Upper left

Lower Right Lower Front Lower Left

Is the pain severe or waking you up at night? Yes No

What is your main purpose of your visit today? ____

How long since your last dental visit? ____

What was the visit for (Please Circle)? I had a problem I needed fixed General Check-up

When was the last time you had a general check-up of all of your teeth? ______________________

How often do you have your teeth cleaned by a Dentist? ____________________________________

Has anything stopped you from visiting the dentist? What? __________________________________

What did you like about your previous dentist? ____

What didn't you like about your previous dentist? ____

1.Do you floss **less** than once per day?	Yes No
2.Do you brush **less** than twice per day?	Yes No
3.Are you **unsure** how to clean your teeth properly?	Yes No Unsure
4.Do you find it painful to brush or floss?	Yes No
5.Do you mostly drink tank, filtered, or bottled water?	Yes No
6.Do you use a mouth rinse?	Yes No
7.Do you drink fruit juice, sports drinks, soft-drink, diet sodas or energy drinks?	Yes No
8.Do you eat citrus fruits (e.g. lemons, tomatoes, oranges)?	Yes No
9.Does your breath concern you?	Yes No
10.Does the colour of your teeth concern you?	Yes No
11.Are you aware of any crowding in your teeth?	Yes No Unsure
12.Do you snore?	Yes No Unsure
13.Do you stop breathing while asleep?	Yes No Unsure
14.Do you breathe through your mouth?	Yes No Unsure
15.Do you play sport?	Yes No
16.Do you get any clicking/pain in your jaw joints?	Yes No
17.Do you wake up with a headache/sore jaw?	Yes No
18.Do you have a dry mouth?	Yes No Unsure
19.Are you concerned about any gaps or spaces in your mouth?	Yes No
20.Are you aware of grinding or clenching during the day or night?	Yes No Unsure
21.Have you been told you grind while asleep?	Yes No
23. Do you get headaches more than once per week	Yes No

22.What would you change about your smile? ____

I have answered all questions truthfully and to the best of my knowledge. Should further information be necessary, you have my permission to request that information from the respective health care provider and for them to release to you, possibly by an email that may lack complete encryption. You also have permission to disclose my medical information only for the purpose that may be relevant for my treatment, in order to achieve the safest and highest standard outcome for me, and not for any other purpose. I will notify the doctor of any changes in my health or medication. I agree to the publication of my clinical photos for educational purposes for dental professional and to educate the public, provided my identity is removed and I am not able to be identified from my clinical photos. I accept that my nominated responsible party, or myself, is responsible for any incurred dental fees.

FEES:

☐ **Limited Consultation (assessment of one specific tooth or problem) – $101**
☐ **Comprehensive Consultation (assessment of multiple teeth issues *or* an appraisal of all of the teeth) - $199**

Quotes include X-rays, Photos, Special Tests. After hours fee is an extra $250
I understand that Dentaltown must receive fees on the day, either by

1) Payment through a third party (E.g. Medicare, DVA, Health Fund, Promotion)
2) Cash, EFTPOS, Credit, Cheque
3) Utilising a Dentaltown Payment Plan (**IF YOU WOULD LIKE THIS OPTION, YOU MUST ADVISE FRONT DESK STAFF IN ORDER TO APPLY – ELIGIBILITY CRITERIA APPLIES)**

I have read and understand the above declaration

Signed...Date...

Dentist Signature………………………………. Date………………………………