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.

Please circle Mr. Mrs. Miss. Ms.		First Name:	
Preferred Name:		Last Name:	
Date of Birth: / /		Occupation:	
Home Address: Suburb: Postcode: State:		Postal Address: (Leave if same as Home Address) Suburb: Postcode: State:	
Phone (H) Phone (W) Mobile	☐ _____ ☐ _____ ☐ _____ (Please tick your preferred contact)	How did you hear about us? (Please circle):	Friend/Family (**Name:** _____) Google Facebook Radio Flyer Walked Past Dentaltown Staff
Email:	_____@_____		
Emergency Contact: Name: Relation: Phone:		**Responsible for Fees** (leave if you are responsible)**:** Name: Relation: Phone: Address:	
Health Fund (if you have one): Health Fund Number: _____ / _____			

MEDICAL HISTORY

Name of your Medical Doctor: _____ Tick if you **don't** have a regular Medical Doctor ☐	Phone:
Your Doctor's Address:	

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	Bleeding medications	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
Antidepressants	Yes No	Reaction to local anaesthetics	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? _____
What is your short- & long-term goal? _____

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 general colour of your teeth concern you?	Yes No
11.Are you aware of any crowding in your teeth?	Yes No Unsure
12.Do snore regularly?	Yes No Unsure
13.Have you been diagnosed with sleep apnea?	Yes No
14. Do you experience tiredness or sleepiness during the day?	Yes No Unsure
16.Do you play sport?	Yes No
17.Are you aware of grinding or clenching during the day or night?	Yes No Unsure
18.Do you get headaches/sore jaw in the mornings?	Yes No
19. Do you suffer from any knee/hip/back/neck or shoulder pain	Yes No
20.Do you get any clicking/pain in your jaw joints?	Yes No
21.Do you have a dry mouth?	Yes No Unsure
22.Are you concerned about any gaps or spaces in your mouth?	Yes No
23.Have you been told you grind while asleep?	Yes No
24.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) – $120

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……