CONFIDENTIAL PATIENT HISTORY FORM
Member of the Australian Dental Association

ENHANCE DENTAL
Level 2, Suite 219
566 St Kilda Rd Melbourne, Australia, 3004

Name: **Birth Date:** **Today's Date:**

□Dr □Mr □Mrs □Ms □Miss □Master

Home Address: **Work Address:**

Suburb:

Post Code: **Home Ph:** **Work Ph:**

Email: **Mobile Ph:** **Occupation:**

DETAILS OF PERSONS TO CONTACT IN AN EMERGENCY:

Name: _____**Ph:** _____ **GP's Name:** _____**Ph:**_____

MEDICAL HISTORY: **(Please tick all boxes required)**

1. **Are you receiving any medical treatment at the present time?** ☐ **YES** ☐ **NO** _____ (Details)
2. **Have you taken medicine, tablets, capsules, or drugs recently?** ☐ **YES** ☐ **NO** _____ (Details)
3. **Have you ever experienced any allergies?** ☐ **YES** ☐ **NO** _____ (Details)
4. **Are you at risk to HIV exposure?** ☐ **YES** ☐ **NO**
5. **Females, are you contemplating pregnancy / pregnant now?** ☐ **YES** ☐ **NO**
6. **Have you ever had any type of bone disease or cancer requiring Bisphosphonate medication in the past?** ☐ **YES** ☐ **NO**

7. DO YOU HAVE A HISTORY OF? **(ONLY TICK BOXES IF THE ANSWER IS "YES")**

- □ Aids or HIV
- □ Anaemia
- □ Anorexia
- □ Arthritis
- □ Asthma
- □ Blood Pressure □High / □Low
- □ Bleeding Problems
- □ Breathing Problems
- □ Bulimia
- □ Bone Disease
- □ Chest Pain
- □ Cold Sores
- □ Depressive Illness
- □ Drug Dependence
- □ Gastric Problems
- □ Epilepsy
- □ Heart Problems
- □ Heart Valve Surgery
- □ Hepatitis – □A, □B or □C
- □ Infectious Disease
- □ Kidney Disease
- □ Liver Disease
- □ Multiple Myeloma
- □ Osteoporosis
- □ Paget's Disease
- □ Penicillin Allergies
- □ Prosthetic Surgery
- □ Recreational Drugs
- □ Rheumatic Fever
- □ Severe Headaches
- □ Smoking. How long for ?_____
- □ Tuberculosis
- □ Any Other Illness: (Specify below)

REFERRED BY (Please tick all boxes required) _____

□ Friend / Patient (Name)_____ or □ Health Provider (Name)_____

□ Internet □ Internet reviews □ Radio □ Yellow Pages □ Magazine □ Newspaper □ Street Sign □ Other

8. Have you visited www.enhancedental.com? □YES □NO Any Comments? _____

9. What is your Dental Insurance? □HBA □Medibank Private □Aust. Unity □None □Other_____ (Details)

10. Please indicate which methods of payments you will use to settle your account today.

□Cash □Eftpos □Credit Card (Diners Club is not available)

- **Either a standard consultation fee or examination fee of $86.00 applies at your first visit.**
- **Cheques will not be accepted unless it is a bank cheque arranged prior to your appointment.**
- **Please enquire about fees for general dental procedures at front reception desk.**
- **If professional fees today are in excess of $600 you will be informed prior to treatment.**

DENTAL HISTORY:

1. What is the most important thing you would like done at your visit today ?

2. Please specify anything else you would like to discuss at today's visit ?

3. Approximately when was your last ……

…dental check up ?	_____ months ago	_____ years ago
…scaling and/or cleaning ?	_____ months ago	_____ years ago
…dental X-rays ?	_____ months ago	_____ years ago

4. How often do you <u>normally</u> see a dentist ? (Please tick boxes)

□ More than twice per year	□ Once per year	□ Mainly when feeling discomfort
□ Twice per year	□ Less than once per year	□ Almost never

5. Are you having any □pain or □discomfort that you would like to have treated today ? **□ YES □ NO**

6. Would you like your teeth thoroughly cleaned today <u>if time permits</u> ? **□ YES □ NO**

7. Have you ever had any problems with past dental treatment ? □Low quality □Painful procedure □Other **□ YES □ NO**

8. Do you have any gum problems ? □Bleeding □Red □Swollen □Sore □Receding □Gummy smile **□ YES □ NO**

9. Do you ever have tooth pain or discomfort when chewing <u>hard</u> foods ? □Rarely □Occasional □Often **□ YES □ NO**

10. Would you like to find out if your teeth can be whitened noticeably more than cleaning can provide ? **□ YES □ NO**

11. Would you like to consider improving your teeth's appearance or having a Smile Makeover ? **□ YES □ NO**
□Crooked □Protruding □Gaps □Hidden □Too Big □Too Small □Chipped □Worn □Smile Makeover

12. Are you considering replacement of any black metal fillings with natural tooth coloured fillings ? **□ YES □ NO**

13. Are you considering replacement of any missing teeth to □improve appearance or □chew food better ? **□ YES □ NO**

14. Would you like to consider replacement of old crowns (caps) or veneers that don't match ? **□ YES □ NO**

15. Are you aware of any clenching or grinding of your teeth ? □Mild □Moderate □Severe **□ YES □ NO**

16. Do you ever have frequent □headaches, □earaches, □jaw joint problems or □neck problems ? **□ YES □ NO**

17. Do you snore loudly or find that your partner gives you a nudge when you snore at night ? **□ YES □ NO**

18. Do you often feel tired, fatigued, or sleepy during the daytime? **□ YES □ NO**

19. On a scale of 1 to 10, with 10 being the highest rating: (Please Circle)

How important is your dental health to you ?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health ?	1	2	3	4	5	6	7	8	9	10
How important is the appearance of your smile ?	1	2	3	4	5	6	7	8	9	10
Where would you rate the current appearance of your smile ?	1	2	3	4	5	6	7	8	9	10

20. Previous dentist's name ? _____

Suburb: _____ State: _____

PLEASE NOTE: PAYMENT IS STRICTLY ON THE DAY OF TREATMENT, THANKYOU

In the event an overdue account is referred to a collection agency or solicitors, the patient will be liable for all legal costs or commissions.
I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk. I also understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other practitioners to aid them in my treatment and give my permission for this to occur when necessary.

I consent to have before and/or after photographs of my teeth used in our dental practice for educational, demonstration or advertising purposes ☐ **YES** ☐ **NO**

SIGNED:
Patient/Parent/Guardian_____Date_____