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
- ☐ Diabetes
- ☐ 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
- ☐ Sleep apnoea
- ☐ Multiple Myeloma
- ☐ Osteoporosis
- ☐ Paget·s Disease
- ☐ Penicillin Allergies
- ☐ Prosthetic Surgery
- ☐ Recreational Drugs
- ☐ Rheumatic Fever
- ☐ Severe Headaches
- ☐ Smoking. How long for ?_____
- ☐ Tuberculosis
- ☐ Stroke / TIA (mini-stroke)
- ☐ Any Other Illness: (Specify below)

REFERRED BY (Please tick all boxes required)

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

☐ Internet ☐ Internet reviews ☐ Radio ☐ Social Media ☐ Magazine ☐ Street Sign ☐ Other

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

9. What is your Dental Insurance? ☐ BUPA ☐ Medibank Private ☐ Aust. Unity ☐ None ☐ Other _____

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

☐ **Cash** ☐ **EFTPOS** ☐ **Credit Card** *(Visa / Mastercard / Amex)* ☐ **HICAPS Claim**

We offer **HICAPS** for instant health fund claims, so you only pay the gap on the day

- **Please enquire about fees for general dental procedures at front reception desk.**
- **Either a standard consultation fee or examination fee of $89.00 applies at your first visit.**
- **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 (select or write a number):

How important is your dental health to you ?	Rating (1-10):	
Where would you rate your current dental health ?	Rating (1-10):	
How important is the appearance of your smile ?	Rating (1-10):	
Where would you rate the current appearance of your smile ?	Rating (1-10):	

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 _____

Electronic copy: type your full name in the signature field. Printed copy: sign by hand.