

Mr / Mrs / Miss / Ms / Master / Dr / Prof / other _____

First Name _____ Surname _____ DOB _____

Address _____

Phone (mobile) _____ Email _____

If you are under 18 years of age, please state Father / Mother / Guardian's name
 _____ Phone _____

Are you eligible for the Child Dental Benefits Schedule (CDBS)? Yes No

Preferred contact method: (please tick) Mobile Email

Emergency Contact: _____ (Tel) _____ Relationship _____

Your Occupation _____ Employer/School _____

Who can we thank for recommending Tooth Heaven? _____

If no one, where did you hear about us? **(please kindly circle one or more)**

Our website (www.toothheaven.com.au) / internet search / walked past / drove past / Facebook / flyer / our flag

Do you have private dental insurance?? Y / N If Yes, name of health fund _____

What is the reason for your visit today? checkup / pain / broken tooth / Other (specify below)

YOUR DENTAL HISTORY

Name of previous dentist _____ Location/Suburb _____

Date of your last dental visit _____ Date of your last scale & clean _____

Have you ever been under the care of a dental hygienist? Y / N

Date of your last in-mouth dental x-ray (not including full face OPG) _____

What do you fear most about coming to the dentist? _____

How often do you brush a day? **(circle one)** *once / twice / more than twice / less than once per day*

How often do you floss? **(circle one)** *daily / 1-2x a week / only if there's food caught / Never!*

Does food get caught between teeth? Y / N

Do you notice bleeding during brushing? Y / N

Do you or your partner notice any bad breath? Y / N

Do you clench or grind your teeth? Y / N

Do you have a "clicking" jaw Y / N

Have you ever woken up with sore jaw or headache? Y / N

Do you have sensitive teeth? Y / N

If yes, to what? **(circle one or more)** *cold / hot / sweets / hard foods / others* _____

YOUR MEDICAL HISTORY

Have you EVER had any of the following? **(please circle)**

Y / N	High / Low Blood Pressure	Y / N	Excessive bleeding or blood disorders
Y / N	Asthma mild / severe	Y / N	Bone problems eg osteoporosis
Y / N	Heart problems _____	Y / N	Epilepsy
Y / N	Heart Pacemaker _____	Y / N	Hepatitis A, B or C ? _____
Y / N	Artificial Heart valve	Y / N	HIV or AIDS last tested _____
Y / N	Artificial Hip/ Joint	Y / N	Stomach ulcers or bowel problems
Y / N	Stroke (when?) _____	Y / N	Tuberculosis or other lung problems
Y / N	Rheumatic fever	Y / N	Thyroid illness
Y / N	Diabetes	Y / N	Urinary/Kidney problems
Y / N	High Cholesterol	Y / N	Athritis
Y / N	Back/neck problems	Y / N	Cancer. If so where? _____
Y / N	Sleep disturbance/apnoea	Y / N	Do You Smoke?
Y / N	For Women, are you pregnant?		
Y / N	Do you have ANY allergies, eg Penicillin, latex (please specify) _____		
Y / N	Are you presently under the care of a medical doctor/ specialist? If yes, for what reason? _____		

Contact details of your medical doctor or specialist

Name _____ Tel _____

Clinic location or address _____

Are you currently taking any medicines, tablets or supplements? Y / N

If yes, please list below (eg aspirin, blood thinners, warfarin, bone strengthener Fosamax)

Please tell us any other medical or dental conditions we haven't covered above.

DECLARATION

- 1) I have completed this questionnaire truthfully and to the best of my knowledge. I understand that failure to make a full disclosure may place ME under medical risk.
- 2) I hereby authorise the dentist or designated team to take x-rays, photographs, models and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- 3) I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- 4) I also give Tooth Heaven permission to use the above contact details to contact me and send me appointment reminders.
- 5) If you have any concerns or wish to restrict access to your information, please discuss with your dentist or receptionist.
- 6) I understand payment is required at the time of service by cash, EFTPOS, cheques, VISA/ Mastercard unless other arrangements have been made. **Please note that a deposit of \$30 may be asked to secure your next appointment.**
- 7) I authorise that this data may be reviewed by team members of the dental practice.

Patient Signature _____ Date _____

Bad dentist joke of the day:

What did the dentist say to the golfer?You have a hole in one