TOOTH HEAVEN

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

Emergency Contact: _____ (Tel) _____ Relationship _____

Your Occupation _____ Employer/School _____

Who can we thank for recommending Tooth Heaven? _____
If no one, how 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)

_____

Are you happy with the appearance of your front teeth? Y / N
If no, what of the following (s) do you want to improve?

Colour/ Crowding / Gaps / Chipped Front Teeth / Stained Old Fillings / Gummy smile

If money wasn't an issue, what would you like to have done with your smile?

_____

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 _____

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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	Arthritis
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 emply 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.
8) Tooth Heaven has a **strict cancellation policy**. When an appointment is made, the time is exclusively booked for you. Any **cancellations within 48 hours will incur a cancel fee**. Please notify us of any changes 48 hours prior to your appointment by calling us at 03 9376 0543. To read more about this policy, refer to our website at www.toothheaven.com.au

Patient Signature _____ Date _____