smilesfirst
Come in for a great smile!

## PATIENT HISTORY SHEET _____

In order for this dental practice to provide the highest standard of care, it is requested that you fill in this form carefully and thoroughly.
All information provided will be kept strictly confidential.

Title: Mr / Mrs / Ms / Dr / Prof / Other (please circle) Minor Child: Miss / Master

Surname: _____ First name: _____

Date of Birth: _____/_____/_____ Ph: _____ Mobile: _____

Email: _____

Address: _____ Suburb _____P/Code: _____

Emergency Contact: _____ Relationship: _____ Ph: _____

Medical Doctor: _____ Ph: _____

Who recommended you to our practice? _____

Do you have dental insurance? □ No □ Yes Which health fund? _____

### PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| High blood pressure | □ | □ | Anxiety/Depression/Mental Illness | □ | □ |
| Diabetes | □ | □ | Physical disability | □ | □ |
| Heart Disease | □ | □ | Asthma, chest or breathing problems | □ | □ |
| Thyroid problems | □ | □ | Rheumatic fever | □ | □ |
| Tuberculosis | □ | □ | Epilepsy | □ | □ |
| Kidney disease | □ | □ | Excessive bleeding or blood disorder | □ | □ |
| Hepatitis | □ | □ | Stomach/Bowel problems (e.g. ulcer) | □ | □ |
| HIV/AIDS | □ | □ | Bone Disease/Arthritis | □ | □ |
| Do you smoke? | □ | □ | How many? ____/day | | |

Medicinal allergies (e.g. Penicillin, Latex, etc)? Y / N Please specify _____

Environmental allergies (Nuts, Grass, Pets, etc)? Y / N Please specify _____

Artificial hip, knee, heart valve or prosthetic implant? Y / N Please specify _____

Taking any drugs, medicines or tablets? Y / N Please specify _____

List any past or present illnesses not covered above _____

Female patients, are you pregnant? Y / N
Have you ever had problems with dental treatment? Y / N
Do you experience headaches/ migraines/ jaw problems frequently? Y / N

I have completed the questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. □ Please Initial_____

I consent to photographs and x-rays being taken as required for my dental care. □ Please Initial_____

I understand that I will be charged a cancellation fee if I fail to attend or fail to give notice at least 24 hrs prior my appointment. □ Please Initial_____

I understand that my dental treatment is to be PAID IN FULL on the day of treatment. □ Please Initial_____

Name of Patient/ Parent /Legal guardian: _____Sign:_____

Date: _____/_____/_____

Please Turn Over

At Smiles First, we have **four values** that drive our quality of care. All of them are really important to us, and we would like to know which of the following is **most** important to you. **(Please tick one)**

- □ Comfort - Feeling comfortable/relaxed during and after your visit.
- □ Function - Being able to chew, speak and clean your teeth properly.
- □ Cosmetic - Being happy with your smile and how your teeth look.
- □ Longevity - Meaning long-lasting results and keeping your teeth and gums healthy.

When considering future treatment, would **any** of these be a barrier or concern for you?
**(Please any that could apply)**

- □ Time
- □ Fear
- □ Trust
- □ Budget

## Oral Hygiene Questionnaire

**Please circle how you feel about your smile on a scale of 1-10:** **1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

1. How often do you visit the dentist?

- □ Every 6mth
- □ Every year
- □ When in pain
- □ Not regularly

2. What prevented you from visiting the dentist regularly? _____

_____

_____

3. How often do you brush your teeth? _____

4. What do you use to clean your teeth?

- □ Tooth Brush
- □ Tooth Paste
- □ Floss
- □ Toothpick
- □ Mouth Rinse
- □ Tongue Cleaner

5. Do you experience any of the following?

- □ Bleeding gums
- □ Sensitive teeth
- □ Bad breath
- □ Dry mouth

6. Do you know gum disease has a direct link to your heart and general health?

- □ Yes
- □ No

**THANK YOU**
**AND**
**WELCOME TO SMILES FIRST.**