**Welcome to Cosmetic & Laser Dentistry Centre**

**So that we may provide you with the best possible care, please complete our medical/dental history form. Please note that all information is completely confidential.**

**Important: Please complete all 5 pages (signatures required on pages 6 & 7)**

Surname: _____ Title: ☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr ☐Other _____

Given Name: _____ Date of Birth: _____

Preferred Name: _____

Address: _____ Postcode: _____

Postal Address: _____ Postcode: _____

PH: Home: _____ Work: _____ Mobile: _____

Email: _____

Occupation: _____ Employer: _____

Do you have Private Health Cover? Yes / No

If yes, please specify which fund: _____

Person responsible for account: _____

Telephone: _____

Address: _____ Postcode: _____

**Next of Kin**

Full Name: _____

Relationship to you: _____

Telephone: _____

Address: _____ Postcode: _____

**Whom can we thank for recommending you to this practice?**

☐Existing Patient (please name): _____

☐Dentist ☐Doctor ☐Solicitor

☐Television ☐Newspaper ☐Magazine (please specify): _____

☐Staff Member ☐Yellow Pages ☐Internet (please specify): _____

☐CLDC website ☐Glamsmile website ☐Other (please specify): _____

What is the reason for your dental visit today? _____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-rays _____

Previous dentist's name _____ Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss? _____

What other aids do you use? (interproximal brush, tooth pick, etc.)

Do you have any dental problems now? Yes / No

If yes, please specify: _____

## Medical History

Have you ever been under the care of a medical doctor during the past two years?

If yes, please specify _____

Physician's name _____ Phone _____

Have you been a patient in hospital over the past five years? _____

Are you happy with the overall appearance of your face? Yes / No

If no, please provide details _____

Have you ever had **Botox or Dermal Filler Treatments**? Yes / No

If yes, when was your last treatment? _____

If known, please advise of the product and dosage used at the time _____

Did you experience any problems or reactions to the treatment provided and were you happy with the results?

_____

**Do you suffer from any of the following conditions? Please tick the appropriate response and provide details below.**

| Condition | Now | Previously | Please Specify |
|---|---|---|---|
| Heart disease/Arrhythmia | | | |
| Heart murmur/Congenital heart disease | | | |
| Heart surgery/Valve replacement | | | |
| Rheumatic fever | | | |
| Pacemaker | | | |
| Stroke/mini stroke | | | |
| Blood clots/DVT/PE | | | |
| High blood pressure | | | |
| Blood disease/Bleeding disorder | | | |
| Arthritis/Osteoporosis/Joint replacement | | | |
| Hepatitis A, B or C / Carrier of Hepatitis | | | |
| HIV/AIDS | | | |
| Thyroid disorder | | | |
| Asthma/Bronchitis/Sinusitis/Lung disease | | | |
| Sleep apnea | | | |
| Liver disease | | | |
| Kidney disease | | | |
| Epilepsy/Seizures | | | |
| Fainting/Dizzy Spells | | | |
| Reflux/Stomach Ulcers | | | |
| Diabetes | | | |
| Cancer | | | |
| Radiotherapy/Chemotherapy | | | When: |
| | | | Site: |
| History of blood transfusions | | | |
| Use of intravenous drugs | | | |
| Anxiety/Depression/Psychiatric illness | | | |
| Smoking history | | | Year started: |
| | | | Year quit: |
| | | | No. per day: |
| Alcohol intake | | | No. standard drinks per day: |
| Other health problems? Please list if any | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Do you have any allergies? Eg: Local anaesthetic, latex, penicillin, peanuts**

If yes, please specify below:

_____

_____

**MEDICATIONS LIST**: Please provide a detailed list of ALL prescription and non-prescription medications you are currently taking and the doses e.g. Aspirin 100mg 1 tablet once a day, Endep 25mg 1 tablet once a day, etc including herbal medicines such as St John's Wort, Ginko Biloba, etc.

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you taking, or have you taken **bisphosphonates** (eg. Fosamax, Aredia, Aclasta, Actonel, Didronel, Reclast, Pamisol, Skelid, Zometa) for:

☐Osteoporosis ☐Paget's disease ☐Bone cancer, cancer spread to bones ☐Multiple myeloma ☐Other

If previously taking **bisphosphonates**:
When did you stop taking them? _____
How many years did you take them? _____

Would you like to discuss any of the above in private with the dentist? **Yes / No**
Have you lost or gained more than 4.5 kilograms in the past year? _____

**Are your teeth sensitive to:**

| | |
|---|---|
| Hot or cold | Yes / No |
| Sweets? | Yes / No |
| Biting or chewing? | Yes / No |
| Have you noticed any mouth odours or bad tastes? | Yes / No |
| Do you frequently get sores, blisters or any other oral lesions? | Yes / No |
| **Do your gums bleed or hurt?** | Yes / No |
| Have your parents experienced gum disease or tooth loss? | Yes / No |
| Have you noticed any loose teeth or change in your bite? | Yes / No |
| Does food tend to become caught between your teeth | Yes / No |

If yes where? _____

**Do you:**

| | |
|---|---|
| Clench or grind your teeth while awake or asleep | Yes / No |
| Bite your lips or cheeks regularly? | Yes / No |
| Hold/bite foreign objects in your teeth? *(Pencils, pipes, pins, screws, fingernails, straws)* | Yes / No |
| Breathe through your mouth while awake or asleep? | Yes / No |

**Women Only:**

**Are you:**

| | | |
|---|---|---|
| Pregnant? | Yes / No | If yes, how many months: _____ |
| Nursing? | Yes / No | |
| Taking birth control pills? | Yes / No | |

**Have you ever:**

| | |
|---|---|
| Had orthodontic treatment | Yes / No |
| Had oral surgery | Yes / No |
| Had periodontal treatment | Yes / No |
| Had your teeth ground or your bite adjusted | Yes / No |
| Had a bite plate or a mouth guard | Yes / No |
| Had a serious injury to the mouth or head | Yes / No |
| Had any previous problems with dental infections | Yes / No |

*If you answered yes to any of the above, please describe, including cause:*

_____

_____

**Do you suffer from any of the following jaw symptoms?** (Please circle appropriate response & side of the face)

| | | | | | | |
|---|---|---|---|---|---|---|
| Clicking jaw? | Yes | No | Sometimes | Left | Right | Both |
| Jaw locking open? | Yes | No | Sometimes | Left | Right | Both |
| Jaw locking shut? | Yes | No | Sometimes | Left | Right | Both |
| Grating or grinding jaw noises? | Yes | No | Sometimes | Left | Right | Both |
| Limited opening? | Yes | No | Sometimes | Left | Right | Both |
| Clench or grind your teeth whilst awake or asleep? | Yes | No | Sometimes | Left | Right | Both |

**Have you ever experienced?**

| | |
|---|---|
| Difficulty in chewing on either side of the mouth? | Yes / No |
| Headaches, neck aches or shoulder aches? | Yes / No |
| Sore muscles (neck, shoulders)? | Yes / No |
| **Are you satisfied with your teeth's appearance?** | Yes / No |
| Would you like to keep all of your teeth for the duration of your life? | Yes / No |
| Do you feel nervous about having dental treatment? | Yes / No |
| If so, what is your biggest concern? | Yes / No |
| Have you ever had an upsetting dental experience? | Yes / No |

If yes, please describe _____

_____

Is there anything else about having dental treatment you would like us to know?

_____

_____

_____

_____

On a scale of 1-10, how would you describe your level of anxiety level about your visit today? Please circle below.

*Least anxious* *1* *2* *3* *4* *5* *6* *7* *8* *9* *0* *Most anxious*

Please note that our policy is to receive payment on the day of your treatment.

We accept Cash, EFTPOS, Visa, MasterCard and American Express.

*In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.*

Signature: _____ Date: _____

48 hours and no less than 24 hours notice of inability to keep an appointment is requested. Failure to do so will result in a fee, if we have not had enough time to permit booking another patient for the same time.

**NOTICE FOR PATIENT INFORMATION**

*Your Health Information and our Privacy Policy*

**In accordance with the Victorian Health Records Act 2001 and Privacy Act**

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed. The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2. We may disclose your health information to other health care professional, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Signature: _____ Date: _____

Parent/Guardian Name: _____

Dependent(s): _____

*This page intentionally left blank:*

**Notes:**